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# REVIEWING SPENDING PROPOSALS OF THE PRESIDENT'S BUDGET

## HEARING

BEFORE THE

## COMMITTEE ON FINANCE
## UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

MARCH 3, 1988

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# REVIEWING SPENDING PROPOSALS OF THE PRESIDENT'S BUDGET

THURSDAY, MARCH 3, 1988

U.S. SENATE,
COMMITTEE ON FINANCE
*Washington, DC.*

The hearing was convened, pursuant to notice, at 10:08 a.m. in room SD-215, Dirksen Senate Office Building, the Honorable Lloyd Bentsen (Chairman) presiding.

Present: Senators Bentsen, Matsunaga, Baucus, Bradley, Mitchell, Pryor, Rockefeller, Daschle, Packwood, Danforth, Chafee, Heinz, and Durenberger.

[The prepared written statement of Senator Bentsen appears in the Appendix:]

[The press release announcing the hearing follows:]

BENTSEN ANNOUNCES FINANCE COMMITTEE HEARING ON PRESIDENT'S BUDGET

WASHINGTON, DC.—Senator Lloyd Bentsen (D., Texas), Chairman, announced Wednesday that the Committee on Finance will hold a hearing on the President's budget to review spending proposals within the Committee's jurisdiction.

The hearing is scheduled for Thursday, March 3, 1988 at 10:00 a.m. in Room SD-215 of the Dirksen Senate Office Building.

Bentsen said, "The President's budget numbers accurately reflect the budget agreement reached by Congress and the Administration last fall. His deficit, however, is twice as large as the federal deficit of 1980 and it relies on very optimistic economic assumptions."

"This hearing will afford Finance Committee members the opportunity to question representatives of the Administration on their proposed spending changes contained in the fiscal year 1989 budget," Senator Bentsen said.

## OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM THE STATE OF TEXAS, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. This hearing will come to order.

I understand Director Miller is on the way and should be here at any moment.

Mr. Secretary, we are very pleased to have you and some of your associates here this morning at this budget hearing. I don't want to see the Administration reopen the Summit agreement by insisting on another round of Medicare cuts. If that is done, I think we will have a pretty rocky year. Up to now, there seems to be general agreement that as the budget that was submitted by the President generally conforms with the Summit agreement reached that year.

I am please that you are here, Mr. Secretary, to share with us the policy rationales underlying the Administration's recommended changes in the Medicare Program, some which would result in budget savings.

A substantial portion—74 percent of the proposed savings—come from further reductions in payments to hospitals.

I would be interested in hearing from you, Mr. Secretary, about a problem we face every year. The Medicare spending reductions rely heavily on restraining hospital spending, despite the fact that the American Hospital Association and the Inspector General advise us that nearly one-half of all hospitals will lose money on their Medicare patients this year.

There was a time there when these hospitals were making very substantial profits, but that margin has narrowed each year as the Administration has taken action and the Congress has taken action cutting back on hospital payments.

The number of hospitals that are going to be losing money is expected to grow in future years unless we alter that budget cutting policy.

The 1989 budget includes $980 million in proposed cut backs in hospital payments and focuses those reductions on teaching hospitals. I am especially concerned about the potential impact of cutting the indirect teaching payment all the way back to 4.05 percent.

In the direct medical education area, Mr. Secretary, I want to commend you for protecting Medicare support for nursing education, an area in which the Administration has previously proposed cuts.

I would also like to note that while I am pleased to see that the Administration has dropped its ill-advised proposal for a cap on Medicaid spending, the budget does assume that the Secretary will issue certain regulations which would reduce Medicaid spending by $413 million in fiscal year 1989.

Now let me say a word about those regulations. Mr. Secretary, I am sure you are aware that several members of this Committee are from states that would be severely affected should the Department move to limit the use of donations as the State's share of Medicaid. I know that is a particular concern to Senator Rockefeller, and perhaps to Senator Pryor. It is sure an issue in my own State of Texas.

Mr. Secretary, I hope you will keep us apprised of developments in that area.

There are some further concerns. I am dismayed, for example, that the Administration once again proposed to mandatorily extend Medicare to all State and local employees, We have had that issue in this Congress before and it has been defeated.

In the welfare area, however, I note that the President's budget includes modest funding for a welfare reform program. The amount is based on a specific proposal, and the bill that ultimately becomes law will likely differ substantially from that proposal. But I take the President's inclusion of this item in his budget as an encouraging sign that the Administration intends to cooperate in advancing that important issue toward enactment.

The House has passed a bill. This Committee and Senator Moynihan's Subcommittee have spent much time and effort exploring the issue in hearings. And it would really be a mistake not to conclude that matter this year. I want to see it done.

I am very hopeful we will be able to put together a bill which the House, the Senate, you, Mr. Secretary, and the President can en-

dorse to help families with children improve their lives and free themselves from dependence on welfare.

We are facing more and more competition worldwide. It is terribly important that all members of our society—to the extent possible—be productive members of the workforce and keep this Nation competitive. At the same time welfare reform can make a difference by bettering the lives of those that have been living on welfare and would like to work their way off of it. That is the kind of legislation we are seeking.

I would like to now defer to any of my colleagues who have any comments to make. Senator Packwood.

Senator PACKWOOD. No statement, Mr. Chairman.

The CHAIRMAN. Senator Matsunaga.

Senator MATSUNAGA. I have no statement, Mr. Chairman.

The CHAIRMAN. Senator Mitchell.

## OPENING STATEMENT OF HON. GEORGE MITCHELL, A U.S. SENATOR FROM THE STATE OF MAINE

Senator MITCHELL. Mr. Chairman, I would like to make a brief statement.

So as not to be time consuming, I associate myself with your remarks. And I would just like to say, Secretary Bowen, we look forward to working with you. But I, for one, cannot support the proposed reductions in Medicare proposed in the President's budget.

We worked to develop a compromise on the budget last year, and you were very much involved in that. Senator Chafee and I spent over a week, long days and nights, implementing the $5.5 billion in cuts that were mandated by the budget summit agreement, and we did that in the belief that we were acting on the basis of a binding agreement. And I think with the Administration coming back now proposing these additional cuts under the guise of an allegation that we did not meet the targets set forth in the agreement is really inappropriate.

The reductions that we agreed to in Medicare were very difficult to achieve. Hospitals expressed serious concern about their ability to provide quality care to Medicare patients in light of the modest update factors that we agreed to. And I believe that the concerns of the hospitals, as expressed, were well founded. And I do not think we can or should go beyond what was in the agreement.

And so I, for one, will strongly oppose any effort to make further reductions in this immediate coming fiscal year beyond those that we agreed to and that we implemented with great difficulty.

I would just say that on the other subject of the mandating of Medicare for all State and local employees, I understand the Administration's position on that policy, and there is disagreement on this Committee, but we have discussed, debated and decided that in the past, and I think it is best to let it lay where it is.

I do look forward, Mr. Secretary, to working with you. We have had a good relation, you and this Committee, and our Health Subcommittee, but I just wanted you to know that as far as I am concerned we begin with the premise that we had a deal and we kept our part of it and we expect you to do the same.

The CHAIRMAN. Senator Chafee.

## OPENING STATEMENT OF HON. JOHN CHAFEE, A U.S. SENATOR FROM THE STATE OF RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman.

First, I want to say how nice it is to see Secretary Bowen once again, and we appreicate the opportunity we had to work with you last year as Senator Mitchell mentioned.

I think it is important for everybody to bear in mind that the Medicare program over the past five years has really borne the brunt of the Federal Government's efforts to reduce the deficit. In six years time, Medicare has contributed $30 billion of savings for the deficit, and each year we restrict the funds for reimbursements to hospitals, to physicians and to other health care providers. We have ratcheted this thing down year after year, and I think we have reached the point where we should have—and I know you share—a deep concern about the quality of care that can be provided by those individuals and by the institutions.

And I look at this with a jaundiced eye, this proposal, to make further savings in Medicare because of those facts that I mentioned that others have mentioned also.

As far as the State and local employees, that is a subject we voted on time after time. I have always supported it, but it has not seem to have carried in this Committee. And I am certain the ones who voted for it would be prepared to look at it again, but we are going to have great difficulty on that.

As I understand, the Congressional Budget Office says we met the goals last year. We made the savings. Now apparently OMB disagrees. But I would be very, very reluctant to go back and try to make further savings under the Medicare program.

The CHAIRMAN. I see Director Miller is here and I think a number of these questions will be shared by Director Miller. We are pleased ot have you, Mr. Director. And if you would come on up to the witness table.

Senator ROCKEFELLER. Mr. Chairman, can I add just a word?

The CHAIRMAN. Let me keep on my early burd list here if I may. Well I believe you are right on there. Why don't you go ahead.

## OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM THE STATE OF WEST VIRGINIA

Senator ROCKEFELLER. I share your concerns, Mr. Chairman and those expressed by Senator Mitchell and Senator Chafee. We made a deal last year, and the reduction in Medicare spending that we exacted was extraordinarily difficult to achieve: $2 billion for this fiscal year; $3.6 billion for 1989. That really was a deal, The Senate considered it a deal. There was an arrangement. It was an agreement that was meant to provide stability. Now we have before us more proposed cuts in medicare payments to hospitals and physicians.

We have in West Virginia 35 hospitals which are on the brink of closing right now. We have five that will probably close this year because of financial problems. And you cannot very well have communities attract doctors if those communities and those doctors know that most of their patients are going to be on Medicare or Medicaid or have no health insurance whatsoever.

So I am really inclined to say, Mr. Chairman, that enough is enough. We have done what we need to do to medicare for now. Anymore would be wrong.

Having said that there are some good parts in this budget—and I will always listen to anything that the Secretary has to say—but when it comes to Medicare I think we have done enough. Thank you.

Senator HEINZ. Mr. Chairman, if the Senator would yield.

The CHAIRMAN. Yes. And would you please, if we can, hold our remarks down because I understand that we will probably have a vote on the final passage at 10:30.

Senator HEINZ. Mr. Chairman, I will be six seconds.

The CHAIRMAN. Go right ahead.

## OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator HEINZ. I want to associate myself with the comments of the Senator from West Virginia and other Senators. The cuts proposed to medicare are additional to what we did last year when we cut about as much as we thought we could prudently cut under Medicare. Of particular concern the cuts in indirect graduate medical education that would result in some very profound changes in the way we structured both the reimbursement and the training of physicians and other young health care professionals in this country.

We don't want to get in a position where we cut back on the provider so much that the services to the Medicare beneficiary is negatively affected either now or in the future. Mr. Chairman, I am concerned about these proposals and I obviously want to hear what the Administration has to say about them.

The CHAIRMAN. Mr. Miller, we are delighted to have you here For what may he your final appearance for this Committee.

I must say that despite the lack of usual partisan bickering over a budget, this budget is not free of controversy and it has been presented against a back drop of some serious economic concerns in this country. As presented by the OMB, it meets the target. The CBO believes that it will violate the target for fiscal year 1989 and, in addition, for subsequent years thereafter.

The President has in a very candid interview with the Washington Post admitted that these deficits we are facing are a burden and that they are going to be here long after this President has gone. We are going to have to deal with that legacy. And I don't believe it is going to be corrected by just tinkering around the edges on Medicare.

So the budget proposals relating to Medicare and Medicaid issues are very important. From our way of thinking the Administration's proposals violate the budget summit agreement with respect to those programs and we think focus too much on hospitals, at least I as the Chairman think the priorities are misguided.

You are proposing reductions in medicare spending of $1.3 billion in fiscal year 1989. Now when the proposal first surfaced in January, I wrote you. And we debated the issue at length last year in

the budget summit meetings. So you know that further cuts in medicare are a concern for us, Mr. Director.

And what I would like to do here now is to let Secretary Bowen just go ahead with his testimony, and then Director Miller go ahead with his before any questioning. Because of the time limitations, I want to be sure they get their statements in here.

Mr. SECRETARY.

**STATEMENT OF HON. OTIS R. BOWEN, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY TOM BURKE, CHIEF OF STAFF, DENNIS WILLIAMS, DEPUTY ASSISTANT SECRETARY FOR BUDGET**

Secretary BOWEN. Thank you very much, Mr. Chairman, and members of the Committee. I am pleased to have the opportunity to come before the Committee again and to discuss with you the fiscal year 1989 budget for the Department of Health and Human Services.

With me, to my right, is Chief of Staff, Tom Burke, and, to my left, is the Deputy Assistant Secretary for Budget, Dennis Williams.

Before starting, let me take just a moment to express to the Committee—and it is basically to Chairman Bentsen and Senator Packwood, Senator Mitchell and Senator Chafee—our deep thanks for the leadership role that you took in crafting a bipartisan budget agreement which was acceptable to the administration. I am convinced that our success in seeing a reconciliation bill enacted was due in no small part to your round-the-clock efforts.

The fiscal year 1989 budget for the Department of Health and Human Services reflects the principles established between the Congress and the Administration in the bipartisan budget agreement reached late last year. We seek to achieve meaningful deficit reduction while maintaining our national commitments to health, to income support and to social services.

We also look forward to working with the Congress to shape a budget-neutral, financially sound catastrophic health care proposal, as well as continuing our dialogue on long-term care legislation.

The HSS budget calls for spending a total of $396.8 billion in 1989, which is an increase of 5.8 percent over 1988. It is a budget constructed from clearly established priorities for Health and Human Services, Among these priorities are, number one, increased spending for AIDS; two, a continued protection for Social Security and Supplemental Security Income beneficiaries; and, three, improved quality of care.

For Social Security, the 1989 budget shows total OASDI expenditures of $235 billion, which is an increase of $14 billion over the 1988 figure. These increased Social Security expenditures are due to cost of living adjustments, the normal expected growth in the number of beneficiaries and initial benefit levels. The President's budget includes a full COLA for January of 1989, estimated at 4.2 percent.

OASDI revenues for 1989 keep pace with the increased expenditures and amount to $280 billion, about $22 billion more than 1988.

In the Supplemental Income Program the 1989 outlay estimate is $12.5 billion, which is a decrease of $162 million over 1988. This decrease occurs because there are 13 monthly payments in 1988 and only 12 in 1989. But the rate of Federal expenditures is increasing, due largely to the cost of living increases and more beneficiaries.

Medicare spending is of great concern to us all, and we are estimating a 7.8 percent increase in total Medicare outlays between 1988 and 1989. This would bring 1989 expenditures to $94.5 billion.

Our budget includes a variety of proposals intended to control the rate of health care spending while assuring quality health care and access for program beneficiaries.

To curb the high rate of increase in out-of-hospital costs, we are proposing several legislative changes in 1989 in Medicare Part B to correct certain physician overpayments and to reduce gross spending by over $300 million: Medicare payment to physicians for the 12 "over-priced" procedures reduced by OBRA 1987 would be further reduced by 5 percent. Payment rates for all radiology and anesthesiology services would be reduced by 10 percent and the fee schedules for these services required by OBRA 1987 would be delayed until January 1, 1990. Payment for medical direction of anesthesia services performed by an operating surgeon would be eliminated after December 31, 1988.

We are also proposing several non-physician reimbursement reforms. The fee schedule for the category of durable medical equipment that includes wheelchairs and hospital beds would be based on average allowed charges rather than submitted charges. And we would reduce oxygen payments by 5 percent.

Another proposal would limit payment for beneficiaries who elect to receive home dialysis services directly from a supplier rather than a facility to a national average composite rate.

And, finally, we have a proposal that would establish what is essentially a fee schedule for enteral products and supplies based on wholesale and retail price information.

We believe it is important for consumers to have a stake in cost sharing for routine services. Therefore, we propose to make the 25 percent beneficiary share of the Part B program permanent beginning in 1990. Beneficiaries would be protected by a hold-harmless provision that limits premium increases to preclude an absolute reduction of their Social Security check.

While PPS update factors have reduced average hospital operating margins, there remain subsidies in the hospital system which are clearly excessive. Consequently, the 1989 budget contains almost $1 billion in proposals to reduce Part A Medicare outlays.

One would reduce the Factor used in making indirect medical education adjustments to 4.05 percent. Another proposal would ensure that graduate medical education payments are based only on cost related to salaries and salary-related fringe benefits.

A third proposal would make Medicare secondary payer requirements and enforcement mechanisms more uniform and simplify administration.

To ensure that individuals who now qualify for Medicare on the basis of short periods of work contribute their fair share to the Hospital Insurance Trust Fund, we would include Under Medicare State and local employees hired before March 31, 1986.

To achieve health care quality our major initiative is to increase outlays for peer review organizations to $322 million for 1989, which is up from $191 million in 1988.

The Department continues to be strongly committed to the concept of consumer choice in a health care system to both ensure access for beneficiaries and give them a voice in influencing health care costs.

The Medicaid budget would spend nearly $33 billion in 1989, which is $2 billion over 1988. There are no legislative proposals for Medicaid in this year's budget. However, the budget reflects a number of Medicaid regulatory initiatives designed to encourage more cost-effective health care and clarify reimbursement policies. These regulations would save about $413 million in 1989.

The family support payments to States includes $10.8 billion in outlays for the Aid to Families with Dependent Children Program and the Child Support Enforcement Program. We are especially pleased to report that overall collections for child support payments will total $5 billion in 1989, and this is up 12.4 percent over the previous year.

Also to help reduce unpaid child support obligations in interstate cases, we plan a telecommunications network to link all of the States, increasing the effectiveness of interstate enforcement,

We are asking for your support of S. 1655, the AFDC Employment and Training Reorganization Act of 1987. This legislation contains several features that we consider essential to welfare reform, It would provide broad demonstration authority to enable states and communities to test innovative alternatives to the current welfare system, and consolidate programs and cut out conflicting administrative requirements.

It would also ensure that many people on AFDC receive work and training services, keeping young parents in school or participating in education or job training. It would also allow states flexibility in determining the scope of the AFDC benefits. So states with limited resources could then focus their rescurces on families that they feel are most in need.

Finally, it promotes fiscal restraints in this time of budget deficits.

We are requesting $4 billion in 1989 for programs under the Finance Committee's jurisdiction administered by the Office of Human Development Services. Included in the request is the full authorization of $2.7 billion for the Social Services Block Grant to States which supports child day care, child and adult protection, home management and maintenance, employment and legal assistance, and transportation.

For Foster Care and Adoption Assistance, the budget totals $1.1 billion, an increase of $264 million over 1988 expenditures.

These resources will help to keep families together, support children who cannot live with their families, and provide adoptive homes when reunification is not possible. Included are funds to pay state claims for prior year expenditures.

The Department is working to reduce infant mortality, To help ensure the health of our children, we are supporting expanded efforts by community and migrant health centers to develop targeted

innovative approaches to reducing low birth weight and infant mortality.

The Maternal and Child Health Block Grant is a major component of our effort. Our 1989 request is for $561 million, which is an increase of 6.5 percent.

In conclusion, Mr. Chairman, I believe we have a major opportunity this year to take further steps to control the growth of health care spending and reduce the Federal deficit.

We also have a chance to make historically significant changes in developing the final form of catastrophic health insurance and welfare reform.

I very much look forward to working with this Committee and the Congress to complete these important tasks. Thank you very much.

The CHAIRMAN. Thank you very much, Secretary Bowen. And we, of course, will want to ask some questions concerning your testimony,

Director Miller, we are pleased to have you here to testify.

[The prepared statement of Secretary Bowen appears in the appendix.]

## STATEMENT OF HON. JAMES C. MILLER III, DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

Director MILLER. Thank you, Mr. Chairman.

Let me say, if I could submit my statement for the record. I will not read it.

The CHAIRMAN. Of course, Without objection.

Director MILLER. Let me just summarize if I could and build on what Secretary Bowen has said.

First, let me say that we very much appreciate the Committee's work on catastrophic, H.R. 2470, as passed by the Senate. We think that is a good bill. The AFDC and Child Support Enforcement bill, S. 1655. We appreciate very much the work of the Committee on that. And also very much appreciate the time that you spent on those budget agreement negotiations. I know you were there every day and it was not an entirely pleasant exercise; it was a very prompt one.

As I tell people, we were there 20 days and 20 nights. That is half the time that Noah spent on the Ark. [Laughter.]

And I know Bob Packwood was there and others occasionally.

Let me say, if I could just reinforce what you said, Mr. Chairman—and I know Senator Packwood would say that as well--how important it is that we abide by this agreement. We do have a 2-year agreement, and in an election it is especially difficult I know to meet those kind of strictures, but we have numbers for Defense, we have numbers for International Affairs, we have numbers for Domestic Discretionary Programs, and we have dealt essentially on the Entitlements Programs and an understanding that we would not change Entitlements Programs. And as you can see, this budget is practically devoid of the kind of entitlement reforms that have been included in other budget and I know sometimes that you have proposed.

Let me say with respect to the $1.2 billion Medicare additional savings that we come up with, I would suggest that we not characterize it as a violation of the agreement one way or the other, but to say that we have a difference of expert opinion over whether what we all agreed on in that long session has been met. Whether the full amount of the savings that we agreed on in that session—let's see, what was it, $2 billion for 1988 and $3.5 billion for 1989—has been met.

Now let me just tell you if I could where we are coming from and how we got to the point of figuring that we needed $1.2 billion. And it really is a matter of saying we are consistent. We are coming in with numbers entirely consistent with the agreement.

You, yourself, pointed out a few minutes ago that, we say that we are within the agreement. We meet all the Gramm-Rudman targets. CBO says we do not meet the Gramm-Rudman targets. That is again a difference of expert opinion.

When we put our budget together we put the budget together with our assumptions, with our scoring, et cetera, to meet the agreement as we understand the agreement.

Now as you know, Mr. Chairman, when we began negotiating there was a general understanding at the beginning of the negotiations that we would use the OMB October 20th report, Gramm-Rudman-Hollings report, at the baseline for measuring changes, savings that the negotiators would come up with. And then when you and I sat down, our staffs sat down, and put together the savings package that the Senate passed in reconciliation and we had an agreement there. And the reason we had an agreement is that our experts and your experts sat down and worked it out, worked out all the scoring problems. And this is an innately difficult area to score, as you well know. You have so many different aspects. It is very difficult to score.

But when it went into conference, then we lost it. Then we lost all contact. And the admonition that was contained in the released accompanying agreement that OMB and CBO would get together and resolve the scoring differences we did not have an opportunity to do that. I know it was rushed, and it was very difficult to pull all this together at the last minute, but we did not have that opportunity to be involved in the scoring problems. So we rely on the Medicare actuary at the Department for his assessment of the likely impacts of these different proposals.

And so in pulling together—and I must say also, and, of course, this is not your fault—but we were a little bit concerned that in other areas, such as Agriculture, where OMB's scoring during reconciliation was higher than CBO's in terms of the savings that were forthcoming, OMB's scoring was adopted. And we just ask for some consistency here.

So I think if you will read the testimony—I will not go into it—it lays it out in more detail. There is ample reason for us to believe that to meet the requirements of the agreement we had to come up with $1.2 billion more savings in Medicare.

Now I want to make sure everyone understands. These are not cuts in total Medicare spending. It is just a slow down in the rate of increase in Medicare.

As you know, Mr. Chairman, and members of the Committee, total Medicare spending since 1981 has more than doubled. Total spending on Medicare has more than doubled. And so what we are proposing again is to meet the agreement 100 percent from the standpoint of our experts and how we score the provision in the bill. We are not saying that you violated the agreement. And I think it would probably be appropriate just to view it as a difference in expert opinion. And we can give rhyme and reason why in individual instances we believe that our scoring is preferable. And we look forward to working with you on this matter.

I think Secretary Bowen has covered pretty well the proposals that we have and I will not go into them now in detail. They are in my testimony. The reason being that I understand that you would like to ask some questions and you have some things to attend to later this morning.

Thank you, Mr. Chairman.

[The prepared statement of Director Miller appears in the Appendix.]

The CHAIRMAN. Well obviously we have a difference of opinion over what finally came out of the Reconciliation conference. I go along with you on your analysis right up to the time that we went through the Senate and got into the conference, that long, frustrating conference of 20 days and 20 nights. But I felt at that point that we arrived at using certain numbers that were accepted by the overall conference and signed by the President with some reconciliation to be worked out between the two. And, therefore, I thought—and I still think—that was the agreement and, therefore, I do not believe there is room for discrepancy.

Director Miller. Could I tell you, Mr. Chairman, we worked with Dr. Weiss and others on your staff, and, again, in the Senate bill we did resolve the differences, but in the House bill we were not really admitted as full players in the conference meetings to reconcile these differences. And so when the matter came down—and I visited with the President after we had such a short time—12 hours—to review the CR, and about eight hours to review, reconciliation—when we added it all up and made all the scoring, I told the President that, in our judgment, the Medicare savings are not equal to those in the agreement, although the total amount of savings for the fiscal year were sufficient did come up to the right amounts. And so I recommended to the President that he sign it. But his signing it I don't think should be interpreted as necessarily an affirmation that the changes——

The Chairman. Well, Mr. Miller, that is the way I read it. Once a fellow signs a contract I think that is it.

But let me also state that we have a provision in the Reconciliation bill that ought to go a long ways toward resolving those discrepancies between the OMB and the CBO in scoring by establishing a statutory method for projecting the Medicare hospital payment increases. And that budget baseline will now use an update that reflects market basket cost increases, so that OMB and CBO will be working from the same assumptions, as I understand it.

Dr. Bowen or Mr. Miller, either one, the budget proposes to achieve savings in the Medicaid program of some $413 million in fiscal year 1989 through a number of regulatory initiatives. That

seems to be a fairly large amount to be saved through initiatives that I don't think are very well defined, such as encouraging States to take certain steps, or to clarify the use of donated funds, to clarify the services that are provided to individuals and facilities for the mentally retarded.

Now can you explain some of those regulations what you are proposing? And specifically I would like to know what services for the mentally retarded would no longer be covered by Medicaid? What changes would be made in the rules relating to the use of donated funds by the States to help finance the Medicaid program?

The availability of those donated funds is critical to some of these States, my own State included. What steps would be taken to encourage States to make recoveries from the assets of medicaid recipients? Now those are some questions I have when you talk about clarifying, I get a little concerned that it is more than cutting out the waste, and fraud and corruption and that sort of thing. I want to know specifically what you are talking about. Either one of you.

Secretary BOWEN. The limitation on the use of donations for 1989 would be a savings of $176 million.

The CHAIRMAN. $176 million on donations?

Secretary BOWEN. In 1989. In 1990, it would be $186 million; 1991, $196 million; 1992, $206 million; 1993, $216 million.

Of course, the objective is to ensure that the States——

The CHAIRMAN. Well how would the rules change insofar as credits for that? I want you to clarify that for me so I can understand it. In the use of those donated funds, how would you change the rules?

Mr. BURKE. Senator, what is at issue in using donations, which in many instances have come from hospitals, as the State's Medicaid share; put against the Federal matching payments the amount of money that a hospital would receive is doubled, or more than doubled.

The CHAIRMAN. I am not sure I fully understand that. Run that one by me again.

Mr. BURKE. The experience we had in West Virginia——

The CHAIRMAN. What would you change in the way you would give credits? That is what I am trying to find out.

Mr. BURKE. Well there is no change actually in the policy. What we are prohibiting is for a State to take donations and use the donations as its part of the match against the Federal share. 50 if it is a 50/50 match for Medicaid, the State uses the donated funds as its 50 percent, puts it against the Federal government's 50 percent doubling the amount of money that it would get.

The CHAIRMAN. Why do you suppose the donations being used as a credit?

Mr. BURKE. Primarily it seems like a way of gaming the system to enhance your Federal share of Medicaid funds. And since many of the donations are in fact coming from hospitals it is a way for the hospital to double the amount of money that it is currently getting.

The CHAIRMAN. You would rather they tax to get that matching share? Is that what you are saying? I would think with your opposition to taxes you would be delighted to have these donations given freely out of the goodness of heart and all of that.

Mr. BURKE. Well, if you consider that we are going to have to tax to come up with the additional Federal share, which would not be there if you hadn't used the——

The CHAIRMAN. But I thought it was sort of the philosophy of this Administration that if we could get individuals to make contributions——

Mr. BURKE. We are not opposed to donations, Senator.

The CHAIRMAN. Uh huh.

Mr. BURKE. We are just opposed to using them to put against your Federal match,

The CHAIRMAN. It seems an inconsistency to me.

Director MILLER. Mr. Chairman, could I respond?

The CHAIRMAN. Sure.

Director MILLER. I mean, basically what happens is the hospitals give monies back to the State which suggests that maybe the total amount of payment is accessed in order for the State then to qualify for 50 percent grant from the Federal Government. We are not against States taxing for their own use. But what this means is basically, because of this operation, Federal taxpayers are paying $176 million too much.

The CHAIRMAN. Well I question that.

Let's get to the other one then on the mentally retarded. What services would no longer be covered?

Secretary BOWEN. The services that deal with education rather than with the medical aspect. And there is a fine line oftentimes there. But audits by the Inspector General and by MCFA in the past two years have really identified a lot of Medicaid claims for educational and vocational activities. Well over $100 million in questionable claims have been identified by our IG.

There are other funds available for the educational efforts.

The CHAIRMAN. All right. Thank you.

We have a vote, and some of the members will be going over to vote, but we will continue here, because I know of your time limitations and ours.

Senator Packwood.

## OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM THE STATE OF OREGON

Senator PACKWOOD. Mr. Secretary and Mr. Director, let me ask you a couple of questions about the trust funds, and the Social Security Trust Fund in particular if I might.

The sources of the information I have, Mr. Secretary, are the budget and Harry C. Ballantyne, who is the chief actuary of the Social Security Administration.

First, let me ask Director Miller, about the way we talk about budget and budget deficits. When we talk about a budget deficit—and it was said last year the budget deficit is $151 billion—that is a net figure. Is that all money in, all money out, including trust funds?

Director MILLER. All money in, all money out difference, yes.

Senator PACKWOOD. So that last year when we had a $151 billion deficit, all money in, all money out, it was actually composed as follows: The $223 billion deficit in non-trust funds.

Director MILLER. I will take that number, yes.

Senator PACKWOOD. Yes, I am talking these from your budget, in non-trust funds.

Director MILLER. Yes.

Senator PACKWOOD. A $53 billion trust fund surplus, other than Social Security, which would reduce the deficit—funds in, funds out—to 170, and then we had a $19.6 billion surplus in Social Security, so it reduces the deficit further?

Director MILLER. That is right.

Senator PACKWOOD. Secondly, when you have surpluses in trust funds, are these monies all invested in Government bonds, or the great bulk of them?

Director MILLER. Yes, they are.

Social Security, by law, must not invest in anything else.

Senator PACKWOOD. Yes. And I think all of the other trust funds are the same except where somebody gives a donation to the Government of some kind.

Director MILLER. Right.

Senator PACKWOOD. But if you mean highway, airport, unemployment compensation, all the big ones are invested in Government bonds.

Director MILLER. That is correct, Senator.

Senator PACKWOOD. All right.

Now, Mr. Secretary, you indicated that the Social Security surplus this year will be $45 billion.

Secretary BOWEN. It will increase by $45.1 billion.

Senator PACKWOOD. We will take in $280 billion and pay out $235 billion.

Secretary BOWEN. That is correct.

Senator PACKWOOD. I am quoting from page 3. But, again those are the same figures that your actuary uses.

That $45 billion, Mr. Secretary, will be used to buy Government bonds and will be counted as part of the deficit reduction surplus.

Secretary BOWEN. Well, yes, the surplus will.

Senator PACKWOOD. Now I want to ask, Mr. Secretary—and again, these are the figures from your actuary—the Social Security Trust Fund surplus is projected to grow as follows: in 1990, $58 billion; in 1991, $69 billion; 1992, $79 billion; 1993, $92 billion surplus.

Secretary BOWEN. Correct.

Senator PACKWOOD. As a matter of fact, the Congressional Budget Office is even slightly more bullish. In 1992, as opposed to your $92 billion, they predict $97 billion, but I don't think that difference is big.

Secretary BOWEN. That depends on assumptions.

Senator PACKWOOD. It does. And they are presuming slightly higher inflation, and therefore, slightly higher pay in. And as the fund is growing, rather than diminishing: the inflation increases rather than decreases the amount.

Secretary BOWEN. That is right.

Senator PACKWOOD. Now I want to go if I can, Mr. Secretary, to your actuary's predictions for years subsequent. And here I have got to say that Mr. Ballentine justifiably uses four scenarios, what I would call most optimistic, next most optimistic, then next most pessimistic and most pessimistic. And the projection that you use

as the reasonable one that OMB uses as the reasonable one, and CBO uses as the reasonable one, is the one that I call second most pessimistic. There are actually two scenarios that are more optimistic than this one. And the following are the projections for the surpluses, as follows, as of last April. I am informed by Mr. Ballantyne they will be updated and they will probably be slightly higher than the ones I read from this chart.

1996—I will start there—surplus of $106 billion. Then they go in 5-year leaps. 2000, $177 billion surplus 2005, $306 billion surplus; 2010, $434 billion surplus; 2015, a $506 billion surplus. I don't mean accumulated surplus. I mean annual surpluses each year.

Secretary BOWEN. Right.

Senator PACKWOOD. And, therefore, the accumulated surplus by the year 2015—it grows even bigger than this, but I am not going to bother to go beyond 2015—the accumulated surplus of more money in than money out in Social Security is $6,900 trillion. Now all of that money is invested in Government bonds.

Does that mean, Mr. Director—and I will give or take a year; I will take 1994, but give or take a year—that the trust fund surpluses in Social Security will be bigger than the accumulated deficits in the rest of the Government?

Secretary BOWEN. Well, it depends on how fast we accumulate surpluses. Excuse me, we accumulate debt. If you look at the numbers, the thing that I was thinking is—you were talking—is we either have to change the law or we had better run big deficits. So we are not going to have enough bonds for Social Security to purchase.

The CHAIRMAN. If I may interrupt, Senator. We have a vote that is now halfway through. If you would like to finish your questioning, fine.

Senator PACKWOOD. I would like to continue when we come back.

The CHAIRMAN. That is fine. We will stand in recess. The first member back will preside,

Senator PACKWOOD. Yes, sir.

The CHAIRMAN. And I have a meeting with Chairman Rostenkowski so I will be over on the House side for that.

And I would think it will take about five minutes.

[Whereupon, at 11:01 a.m., the hearing was recessed.]

AFTER RECESS

Senator MATSUNAGA. The Committee will come to order.

Secretary Bowen, on page 9 of your testimony you say that you have included in the request a full authorization of $2.7 billion for the Social Services Block Grant to States. Title 20, which supports child day care, et cetera. And as you will recall, Senator Riegle was a sponsor of a bill introduced last year, which I cosponsored, to raise the Title 20 authorization level. A $50 million increase in the fiscal year 1988 authorization did pass. However, due to an unintended error, the continuing resolution did not include an appropriation for the additional $50 million.

Neither the President's budget nor the current level of funding granted by HHS to the States under Title 20 acknowledges the full fiscal year 1988 authorized level. Since Title 20 is an entitlement

program, I believe the Federal Government is obligated to provide the States the authorized level of funding.

Title 20 provides grants to the States, as you know, to fund social services programs for children, the elderly, disabled veterans. In fact, it is the largest source of federal support for child care programs. Its funding has been cut in half over the past 10 years, in real dollars, that is.

Why is HHS ignoring the authorized level of funding for Title 20 in fiscal year 1988? Does the Administration intend to request a supplemental appropriation?

Secretary BOWEN. Sir, I don't think we are trying to ignore anything, but it was our impression that the bipartisan budget agreement allows for supplementals only in extreme emergencies. And I guess it depends on the definition of "extreme emergencies".

The one-time increase of the $50 million in the authorization was a Congressional initiative in the Reconciliation legislation, as you know, and we assumed that this action would have been followed through on in the continuing resolution.

Senator MATSUNAGA. Are you opposed to the additional $50 million being projected into the fiscal year 1989?

Secretary BOWEN. Well I am not opposed if it doesn't violate the Bipartisan Budget Agreement. And it was our impression that it would.

Senator MATSUNAGA. Mr. Miller.

Director MILLER. Senator, let me just say that is a mandatory, that is an appropriated entitlement. It is not an entitlement as we normally think of other entitlements. And the CR, the appropriators did not appropriate the money.

So when we sent up the budget, the budget was consistent with current law, which is does not include that extra $50 million. And that is what we sent out for the block grant.

On the other hand, as I have testified before other Committees, when we added all the numbers together on the discretionary spending we came up $100 million short. Now I know this is appropriated Entitlement, but as the Secretary said, obviously this is something we would have to look at. But that is the reason it came up, and we believe that is consistent with the agreement.

Senator MATSUNAGA. Thank you.

Senator Mitchell?

Senator MITCHELL. Thank you very much, Mr. Chairman.

I would like to ask a couple of questions and ask both you, Mr. Miller, and Secretary Bowen to respond.

One of the most promising avenues for reducing costs by reducing the volume of procedures, and at the same time insuring better quality of care is outcomes research. You have been very active in that in the New England area and it has had some very positive results so far. Now I have been introducing legislation in that regard, and I understand that you have placed that research effort into the Health Resources and Services Administration which, to my knowledge, has little or no research capability, instead of the National Center for Health Services Research, which I would believe to be the appropriate place for that.

Can either of you tell me why you have done that?

[The information follows:]

The FY 1989 President's Budget requests $15 million for a Health Care Improvement Fund to be administered by the Health Resources and Services Administration (HRSA), and dedicated to supporting selective assessments of medical technology and practices with the potential for reducing costs without impairing quality of care. Investments from this fund might include grant or contract support for a clinical evaluation of a medical treatment that has never been evaluated for efficacy, or a clinical trial for a new medical technology to compare its efficacy and cost against current treatment for the same illness. Limited private sector investment of this type, such as Blue Cross/Blue Shield's evaluation of the clinical value of 15 common laboratory tests, has already yielded results indicating that many of these tests are overprescribed or unnecessary.

In comparison, the National Center for Health Services Research (NCHSR) conducts research into quality of care and improvement in health services delivery systems. The focus of the Health Care Improvement Fund is specifically cost reduction, and has been requested in HRSA to avoid any conflict of research priorities within NCHSR.

Secretary BOWEN. Tom?

Mr. BURKE. We have been looking at options now for carrying out the quality initiatives in the budget. We have a small initiative going on now in the National Center and we are going to see if we can find some funds to move around in our budget to keep that initiative going.

Senator MITCHELL. All right.

Perhaps this is something with which you would like to respond later in writing. And I would ask you to do that. And I specifically request that you do this in what I think is the proper place. This is something that I am very much interested in and concerned with. I think it is a very promising area for us. And I would like to get any written comments later, and if you cannot do that, the reasons why.

Secretary BOWEN. Well I would simply like to state that I also feel that it is an extremely important research project and it will help us tremendously. It will help [the] physicians also to know what has worked best and what will not work, And I think it will over the long run improve the quality of care.

We want it at the place where we can get the most out of it.

Senator MITCHELL. All right. Thank you.

Next, included in your proposed budget is a significant cut in the rate of reimbursement to teaching hospitals for indirect medical education.

As you know, PROPAC has not yet made a recommendation to Congress for the rate of reimbursement. That is very important to the large teaching hospitals. And those of you, the ones from the rows right behind you who sat through these lengthy proceedings with us knew what a difficult task we had to reach the level of 7.6 percent just last year.

How did you arrive at the figure of 4.05 percent?

Secretary BOWEN. Well, it is my understanding—and, of course that happened before I was here—that the original 8.5 percent, or whatever it was, [—it was about that—] was set just sort of by pulling a figure out of the air. I think our statisticians stated that they felt at first that about 4.5 percent would be the proper figure. And then when pinned down as to whether there was any proof regarding what it should be, no one could say that there was any. So it was just arbitrarily increased, essentially doubled. And they found

that the doubling really has helped the teaching hospitals to get better profits than other hospitals.

Senator MITCHELL. It sounds kind of suspiciously like you are saying that the original figure hadn't been pulled out of the air and a subsequent figure is equally justifiable. Is that the same ground?

Director MILLER. Well the original figure was doubled to 8.1 percent. And then over the last several years it has been whittled down a bit to about I think 7.7 percent that is in reconciliation. The 4.05 is half of the 8.1, which would bring it back to what it was originally. Some of the work done by GAO and by the Inspector General at HHS has concluded that there is a substantial overpayment.

I know there is a difference of opinion with some expert opinion on that, but that is basically the reason, to bring it down to the level that is consistent with what the increment in cost is,

Senator MITCHELL. Well actually, as Senator Chafee will recall, this is a much more important item to the House members, where they represented the large urban centers where the teaching Hospitals are. It was a very contentious part of the debate.

I just have one final question.

Secretary BOWEN. Could I follow up on that just a second?

Senator MITCHELL. Yes.

Secretary BOWEN. The 4.05 is based on a statistically observed relationship now between the teaching programs and the patient care cost, and that has remained fairly constant since PPS started. And here is something that HCFA and CBO agree on, the analysis of this relationship.

Senator MITCHELL. All right. Thank you, Doctor.

I have one final question if I might. One of the features in the budget is in funding for the PRO Program. As you will recall, Doctor—and I think, Mr. Miller, some of your associates will—that is something that Senator Heinz and I were very much interested in during the discussions leading up to final action in 1987. It is a very important part of the ongoing review of expenditures.

Director MILLER. Sure.

Senator MITCHELL. Now one of the reasons we advocated it so strongly was that our feeling was that the current PRO contracts are underfunded.

Now there will be a third scope of work scheduled to begin next year. And my question is, do you intend to take the additional funds and allocate them to the third scope, the new work beginning next year, or do you intend to place them to improve the inadequate funding on the current contract for the work already underway?

Secretary BOWEN. The additional money in the budget will be used to expand the PRO reviews, of course. These expansions would be in the review of HMO and the CMP facilities and ambulatory surgical procedures; in the hospital denial notices; readmissions within 31 days after a discharge; and the care delivered by skilled nursing facilities, home health agencies, and hospital outpatient departments between two hospital confinements; and beneficiary complaints about the quality of the provider services.

Senator MITCHELL. Well, Doctor, if I might just conclude, by saying that is the new scope.

Secretary BOWEN. That is the third round, yes.

Senator MITCHELL. Yes.

If you allocate all the money there, I don't think you are going to deal with the existing problem of inadequate funding on PRO contracts now that don't permit meaningful onsite review, so that you have something that I think everyone agrees is important in controlling both cost and quality, yet resources are inadequate to enable it to be done as effectively as we all would like. And I think this is a good example of where if you put the right amount into it, you are going to save a lot more in the long run.

So I encourage you to utilize at least some portion of these additional resources to whatever extent the budget is approved in meeting the current underfunding in addition to the new scope.

Secretary BOWEN. We recognize the necessity of that.

Senator MITCHELL. All right.

Thank you, Mr. Chairman. I apologize for going over my time.

Senator MATSUNAGA. Senator Packwood, I believe you were in the midst of questions when you had to go to vote.

Senator PACKWOOD. Thank you, Mr. Chairman.

I want to go back to these figures again if I might, Mr. Secretary, and the Director. I am going to cut it off at the year 2020. I think these projections that go beyond that are immense. But in the year 2020, Social Security will have an accumulated surplus of $9,300 trillion—actually, almost $400 billion. When I say I don't want to go beyond, actually in another 10 years they reach $12 trillion. But for the moment, let's go over the next 30 years.

That means, Mr. Director, on the average over the 30, Social Security will take in on the average about $300 billion a year more than it will pay out.

Director MILLER. Yes, sir.

Senator PACKWOOD. And that would mean under the way the law now operates, we would have to in all other functions of government spend on the deficit more than $300 billion a year in order not to have a balanced budget. We would have to have immense deficits the way we now account for the fund:

Director MILLER. That is right.

Senator PACKWOOD. All right.

Therefore—and we are always accusing politics of not looking ahead. And I want to emphasize again, my children are 21 and 17, and I want the Social Security Trust Fund to be there when they retire. And I am fully aware that if we use it up for other things, it won't be there as we promised. I am not suggesting that it be used up for other things. I am suggesting that we are going to have this immense amount of money coming in over the next 30 years that we do not plan to pay out in benefits over the next 30 years under the present law. And that people who to advocate that we need tax increases—other tax increases—to narrow the deficit, are really advocating an increase in the surplus.

If we look over a long period of time, this budget is likely to be in surplus for many, many years because of the investment of the Social Security Trust Fund in the bonds of the Government.

Director MILLER. Well that depends, I think, on the outlay policies of the Government. I mean, certainly the Government could spend the money.

Senator PACKWOOD. I am just talking about actual projections in present law. You are right.

Director MILLER. You are right.

Senator PACKWOOD. And that is why I want to emphasize the sanctity of this fund. If we ever get the idea, we say, wow, $300 billion a year for the next 30 years on the average that we can spend on other things and still have a balanced budget, that will absolutely ruin the fund. It would be immoral, unethical.

Director MILLER. Right.

Senator PACKWOOD. But I am talking now about macroeconomics in the quantity of money.

Director MILLER. And you are going to have a big surplus.

Senator PACKWOOD. We are going to have an immense surplus.

Director MILLER. The Government sector will have a lot more than it spends.

Senator PACKWOOD. I don't even know about the other trust funds as to whether they are in surplus or deficit over the next 10, 20 years. I have not checked those. But, will this be the effect, give or take a year, in 1994, 1995, 1996: at some stage the surplus in the Social Security Trust Fund, based upon at least the projections we are seeing now, ought to be bigger than the rest of the deficit? And this means we would not have to sell any bonds in the private marketplace. Social Security would buy the bonds.

Director MILLER. Well let's keep in mind the stock and the flow. The surplus in the Trust Fund will be very large by 1993 and probably would then certainly exceed the deficit. You would not, let's assume the President's budget for a moment, and we have essentially a balanced budget by 1993, so what we would be looking at is something less than $4 trillion total Federal debt. And, of course, it would be something from the figures that I think we are both looking from, something just past 2005, when you would reach the point where the surplus in the Trust Fund was equal to the total amount of Federal debt outstanding.

Senator PACKWOOD. That is the next question I was going to get at.

By 1995, or so, the annual surplus ought to be bigger than the annual deficit in the rest of the Government.

Director MILLER. I think easily.

Senator PACKWOOD. By the year 2005, the surplus is apparently going to be so big that we could have bought up all those past Government debt.

Director MILLER. Yes. Right.

Senator PACKWOOD. Whatever Japan holds, Germany holds, Prudential holds, Metropolitan holds. Well, assuming they would sell it. They do not have to sell it back.

Director MILLER. Sure.

Senator PACKWOOD. Social Security would hold the entire debt.

Director MILLER. That is correct.

Senator PACKWOOD. Yes.

There is an obligation in the year 2025, 2030, 2035, to pay beneficiaries and we need to remember that. But for the foreseeable

future, when people say the deficit is a problem, under the way that we normally account for the deficit now, for the foreseeable future, we are going to have immense surpluses.

Director MILLER. All that is based on assumptions of a balanced budget, or whatever; that spending does not go out of control, and that we continue to have good growth, et cetera.

Senator PACKWOOD. Yes.

Director MILLER. But becomes the most pessimistic as you described it,

Senator PACKWOOD. The assumption would be, that in order to have deficits, on the average, we would have to spend over $300 billion a year in order to not have a balanced budget based upon the $300 billion a year average surpluses.

Director MILLER. That is correct.

Senator PACKWOOD. Thank you.

Senator MATSUNAGA. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Mr. Miller, following up on what Senator Packwood was saying, and he has, of course, made it very clear that there is a day of reckoning when we have to start paying out these benefits. And that day of reckoning, whether it is 2030 or whatever it is—we don't know—once that starts, the payments are going to go out very, very fast. And, thus, the deficit in the fund, or the reduction in the principal of the Social Security Trust Fund, will go down, very, very rapidly.

Director MILLER. That is true.

Senator CHAFEE. And, thus, if we have not paid attention to income versus expenditures in the Federal Government activities, setting aside Social Security, future generations are going to have a terrible problem on their hands.

Director MILLER. Yes. That is not inconsistent I think with what the Secretary is saying.

Senator CHAFEE. No. Oh, no. I am not suggesting it is. But I just do want to stress that particular point.

Director MILLER. Right.

Senator CHAFEE. And Senator Packwood clearly is not suggesting that this Trust Fund be used to take care of everything in sight.

Dr. Bowen, a couple of questions.

Director MILLER. Senator, could I just mention.

Senator CHAFEE. Yes.

Director MILLER. I think the Senator raised a very important issue that we have got to address down the road, and that is, and from a macroeconomic standpoint, from a stimulative or a cautionary, or what, a restrictive fiscal policy, what we are going to have is a restrictive fiscal policy running great surpluses, assuming that the assumptions underlying these figures are in fact correct.

Senator CHAFEE. And, furthermore, one thing we have learned from Social Security around here is that the national employment figures affect that Fund dramatically.

Director MILLER. Sure.

Senator CHAFEE. As soon as we go into something less than 8 percent employment—unemployment, rather—and get down to 6, the fund takes in the money.

Director MILLER. Higher unemployment, sure.

Senator CHAFEE. On the other hand, high unemployment results in greatly reduced receipts to the Fund.

Dr. Bowen, all of us support obviously the AIDS research. I just noticed in your budget you have a substantial increase in AIDS research of 48 percent or something to that effect.

Secretary BOWEN. Thirty-seven percent.

Senator CHAFEE. Thirty-seven percent. And my question is—and, again, I want to acknowledge that that is not under the jurisdiction of this Committee—but my question is, are you confident that that money can be spent well? Nobody wants to be caught saying no to AIDS research, but at the same time I am not always sure that throwing extra millions at a problem is always constructive. Obviously you have thought this through and your answer is going to be yes, it can be wisely spent.

Secretary BOWEN. You are right. [Laughter.]

Senator CHAFEE. I would be surprised if you said no, it is a great mistake we have made here.

Secretary BOWEN. We are caught between two groups, those that say do nothing, and then those that say spend billions and billions more. We have spent a tremendous amount of time and utilized the talents of many, many individuals and experts to try to come to the proper amount. And, again, who knows exactly what the proper amount is? But the decision is that what we have asked for is proper for right now. That does not mean with some breakthrough that would come it would need an immediate push that we wouldn't call it an emergency and have to ask for more. But I think it is adequate at the present time.

Senator CHAFEE. I want to give you some good news. On page 10 of your statement you talk about the maternal and child health block grant and efforts to reduce low birth rate infant mortality. In our State we have had a dramatic decline in infant mortality, in part as a result, of the funds we have received under this block grant.

Now true are the statistic for some reason seem very old. The latest we have is 1985, through 1985, for some reason. I don't know why Government statistics are not more current. But in any event, I want to report to you, by a determined effort—and we have a state-wide health department that covers the whole state—we have made great success in bringing down infant mortality, And I have always been informed that low birth rate runs concurrent with infant mortality. In other words, the statistics tend to track each other. Am I correct in that?

Secretary BOWEN. You are absolutely correct.

Senator CHAFEE. And so I find that very, very exciting, something I have been deeply interested in. And if we can reach these mothers early enough, not only do we avoid all kinds of tragedies but we also avoid all kinds of expense for the State and Federal Government downstream. So the effort is paying off is my report to you.

Secretary BOWEN. Yes, it is paying off. And if we can get to these mothers early and prevent smoking, alcohol use, and encourage adequate nutrition, we can reduce the number of low birth weight babies and thus reduce the cost of infant mortality.

Senator CHAFEE. Can I ask one more question, Mr. Chairman?

Senator MATSUNAGA. Your time is up, but go ahead.

Senator CHAFEE. All right.

Dr. Bowen, we have got 37 million Americans who do not have any insurance, any health insurance. And it is all well and good for us to wrestle with Medicare, whether this is enough or too little, but what are we going to do with the 37 million Americans who do not have any health care?

Secretary BOWEN. That is one of the big problems that the whole country faces. And I think that we have to work together with the States because I think the States can do a lot more in this area than the Federal Government.

We need to try to get more people covered by insurance programs. Part of the reason that they are not covered is because so many of these 37 million work in places that are small and do not offer health insurance. A great many of them also are self-employed, so that they do not have it. And we think that there are opportunities for the States to improve that situation by perhaps having a system whereby the smaller companies could join together to develop insurance programs. Perhaps the use of some State risk pools would be helpful to those that are uninsurable or who have no insurance.

Senator CHAFEE. You have a task force or some group down there that is working with this, what I consider to be the major health problem in the country now. What we are talking about is the so-called working poor.

Secretary BOWEN. Right.

We studied this when we studied the catastrophic issue because we divided the population really into three segments. One, the acute catastrophic care for those above 65, and then the long-term care for all, but presumably most of them above 65, and then those who are below the age of 65 who had catastrophic expenses. And that would include this uninsured group.

So we do have a report on that with some suggestions in it and we will get you a copy of that if you care to have one.

Senator CHAFEE. All right. I would like to see that.

[The report appears in the Appendix.]

Senator CHAFEE. Mr. Chairman, my time is up. Just let me say that I have a program in called MedAmerica, which works around Medicaid and provides insurance for those who are not totally eligible under the income limitation. And they would pay a fee based on their income in order to obtain this insurance. We have got to address these working poor and the 37 million Americans, some who cannot get insurance even if they can afford it.

Thank you, Doctor.

Senator MATSUNAGA. I might point out that the Labor and Human Resources Committee just reported favorably a bill which would take care of 27 million presently uninsured. It is patterned somewhat after the Prepaid Health Care Program we have in Hawaii.

As you know, Hawaii is the only State in the Union with a law mandating employer coverage of health insurance. We have covered up to 95 percent of all the working people in Hawaii.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Secretary Bowen, as you well know, we are trying to address the differential in hospital payments to rural hospitals compared with urban hospitals, and last year in the Reconciliation bill we have a differential update to try to address that difference.

As you probably also know, PROPAC, in their report that it issued to you this week, points out that rural hospitals are doing even less well than we all thought they were doing when we made our decisions here last year. That is, our decisions were based on 1985 figures, and the 1986 figures show that hospitals were doing even more poorly than we thought.

For example, I think the data for 1986 shows that the average rate of return for an urban hospital is about 8 percent, and the worst returns for urban hospitals was about 9 percent losses, whereas, for rural hospitals—those last figures were urban—urban hospitals, the average rate of return for hospitals was 7.9 percent in the 1986 data, and the worst urban hospitals had losses of about 9 percent.

Director MILLER. Is that a return on investment or return on sales?

Senator BAUCUS. I cannot tell you that. But I do know whatever it is, the comparable figures for rural are not lower, they are dramatically lower.

For rural hospitals, the average is minus 1.7 percent. And the worst 10 percent rural hospital had losses of 48 percent. I cannot answer your question, but all I know it is the same.

Director MILLER. None of these are right.

Senator BAUCUS. That is right.

And the question, therefore, is what is the Administration doing, or what the Secretary, in particular, has in mind to help maintain the trend we are taking to make sure that we compensate hospitals, urban versus rural, on a fair basis?

[The information follows:]

We are taking steps by recommending a PPS update for rural hospitals of the market basket minus 1.5 percent as compared with a PPS update of the market basket minus 2 percent for large urban areas and market basket minus 2.5 percent for other urban areas. Based on current estimates of the market basket index this results in effective updates of 3.1 percent for rural hospitals, 2.6 percent for hospitals in large urban areas, and 2.1 percent for hospitals in other urban areas.

Secretary BOWEN. I share your concern, as you well know and I think that we have taken considerable steps. And I think that what the Congress did in the last couple of years also will be of great help, but I don't think enough time has elapsed to show that as yet.

The figures I have are essentially what you had, that in 1986, the average Medicare profit for all hospitals was 8.93 percent. Urban hospitals had 10.19, and large teaching hospitals had 17.28. But rural hospitals had a lower profit margin of 2.62 percent. So there is a dramatic difference and we are concerned about that disparity. But we are taking some steps: for example, we are recommending that the PPS update for rural hospitals, be the market basket minus 1.5 percent, in comparison to urban hospitals with a one million or more population center having a market basket less 2.0 percent. Other urban hospitals will receive a PPS update of market basket minus 2.5 percent.

We have expanded the swing bed program for hospitals with fewer than 100 beds; that has increased now from 50 beds to 100 beds. So that will help out some hospitals that are a little larger——

Senator BAUCUS. I appreciate that. But new data shows that rurals are in worst shape than we thought they were in. And both the Administration and the Congress have to address that.

Director MILLER. That data goes to the Medicare patients, not to all patients.

Senator BAUCUS. Well that is correct. But are rural hospitals predominantly Medicare hospitals?

Director MILLER. Yes.

Senator BAUCUS. Older people tend to live in rural areas.

Director MILLER. Yes. Your point is right. And Dr. Bowen is right. We are looking at that difference.

Senator BAUCUS. The second area goes to the first subject we discussed this morning, namely, the difference between OMB and CBO on how to cost some of these programs and these reductions.

As you well heard, the Committee is in very strong disagreement with the OMB's analysis. I would like to make the same point when it comes to costing out benefits under catastrophic health insurance. We have that coming before us. And when there is a difference between OMB and CBO, and when the difference is resolved on the move extensive side, it comes out of the hides of taxpayers basically. But in this case, in the catastrophic bill before us, it is not going to come out of the Government's hide or the taxpayers' hide. It is going to come out of the hides of beneficiaries, seniors, because they are paying for it.

Director MILLER. Right.

Senator BAUCUS. So the consequences are much more severe in this case. And I wonder now, are you aware of any differences between CBO and OMB on costing out catastrophic or any of the potential benefits under the catastrophic bill?

Director MILLER. We do have some differences. I think it would probably be best if we answered in writing to amplify on the specifics. And that and welfare reform too we have some differences of opinion.

Senator BAUCUS. All right. If you would do that for the record.

[The information follows:]

Both the Medicare Actuary and the Congressional Budget Office (CBO) are in the process of updating their respective catastrophic health insurance estimates to reflect the most recent baseline assumptions and to incorporate the effects of delayed effective dates.

A comparison of estimates that were released in the fall of 1987 indicate that the CBO's and the Administration's pricing of the first five years of the Senate-passed version of H.R. 2470, are consistent (as a matter of policy the CBO does not estimate costs beyond five years). However, there is a major disagreement concerning the pricing of the House drug benefit—with the Administration's estimate of the five year cost more than three times greater than CBO's. This substantial discrepancy results largely from differences in assumptions about beneficiary utilization of this new benefit. Such differences in pricing a new, "untried" benefit are not uncommon, and emphasize the need for the limits imposed by the Senate's premium-defined benefit.

Senator BAUCUS. One final question if I might, Mr. Chairman, and that is the denial of physician payments. HCFA has instructed its carriers to deny certain payments that it deems are unneces-

sary services. I can tell you, and I have town meetings in Montana. I am accosted by internists, family practitioners, who come up to me outraged that they are given a summary denial. And they cannot for the life of them understand as to why HCFA or its carrier doesn't first determine the reason for their payments requests be reimbursed. And I am wondering if somehow HCFA and the Administration can work out a way for HCFA and/or the carrier to, first, determine why are the physicians first making the claim. Some of these doctors are saying, sure, I saw this patient twice in the same day because she was in a very bad situation. I had to see her twice in the same day. But HCFA is similarly denying it because they say I can only see a patient once.

And I am sure that there are appropriate views; there is no doubt about that, But it also seems the present HCFA procedures seem to be a bit arbitrary.

Secretary BOWEN. One of the things that they have done is that before denial is given they have to contact the physician and find out the circumstances.

Senator BAUCUS. But that is not being done.

Secretary BOWEN. Well it will be done.

Senator BAUCUS. All right. Thank you. That is all I need to know. Thank you.

Secretary BOWEN. Thank you.

Senator MATSUNAGA. Do you have any further questions, Senator Packwood?

Senator PACKWOOD. I have no further questions, Mr. Chairman.

Senator MATSUNAGA. If not, I wish to thank you on behalf of the Chairman and the Committee for being here, Secretary Bowen, Mr. Miller, Mr. Burke, Mr. Williams. I am sure your testimony and your responses to questions will help the Committee in its deliberations.

The Committee stands in recess subject to the call of the Chair.

[Whereupon, at 11:43 a.m., the hearing was concluded.]

STATEMENT OF CHAIRMAN LLOYD BENTSEN
HEARING ON PRESIDENT'S BUDGET FOR FISCAL YEAR 1989
MARCH 3, 1988

Welcome, Director Miller, to what will perhaps be your final appearance before this Committee. Despite the general absence of partisan bickering over the budget due to the December Budget Summit agreement, this budget is far from free of controversy. And I will raise one or two specific issues with you in a minute.

But first, let me note that this budget has been presented against a backdrop of growing economic concern. For example, nearly 80 percent of the economists surveyed last month by the Blue Chip Indicators expect a recession this year or next. Inventories are high and consumer spending fell 3.1 percent in the fourth quarter -- the biggest drop in seven years -- a drop which paved the way, you may recall, for election of the current administration.

Both the CBO and these Blue Chip forecasters are calling for growth this year only two-thirds as high as predicted by the Council of Economic Advisors. And many private forecasters are looking for higher unemployment, as well. As a result, we face some risk that this budget will produce deficits which violate the Gramm-Rudman-Hollings target for Fiscal Year 1989.

CBO expects it will. Moreover, the budget you presented will violate congressional deficit targets for every year after Fiscal Year 1989. But the reality is that in a candid interview last week in the Washington Post, the President for the first time acknowledged that the deficits built into his budgets and accumulated on his watch are a burden. He blames Congress. But the level of spending and, consequently, the deficits which have resulted have been almost exactly what were first proposed by the President. And these deficits are indeed a burden. Interest alone on the deficits just accumulated since 1980 will be $100 billion this year, and more next year -- equal to all the revenue to be collected from American corporations, or equal to one-half the revenues to be collected in Social Security taxes. It's comparable to fully one-third of our defense spending and is ten times what we will spend this year on all science research and space programs. It is more than we will spend combined on agriculture, the environment, housing, science, energy, education at all levels, job training, economic development, air traffic safety, drug abuse and prevention and nutritional programs for the unborn and newborn babies.

True, we have had many budget deficits before. But in terms of the national debt -- and now foreign debt as well -- this administration will leave our nation in far worse shape than was entrusted to them in 1981.

This legacy of an enormous deficit -- which we in Congress will be dealing with long after this administration is gone -- cannot be addressed simply by tinkering at the margins with a little over a billion dollars in Medicare spending reductions. I want to say a word about Medicare and Medicaid now, because I think the Budget in these areas not only avoids the bigger deficit issue but violates the Budget Summit agreement and unfairly focuses on hospitals.

The Budget proposes reductions in Medicare spending of $1.3 billion in Fiscal Year 1989.

When word of proposed Medicare reductions first surfaced in late January, I wrote to you, Director Miller. In that letter, I expressed my dismay that, apparently, the Administration was not going to uphold its end of the Budget Summit agreement we reached in November. As part of that summit agreement, this Committee approved, the Congress adopted, and the President signed, Medicare spending reductions totalling $3.8 billion in Fiscal Year 1989. It was not easy for members of this Committee to balance the critical need for deficit reduction against the needs of elderly Americans for health care. I was gratified that after long, hard work, we developed a package that achieved substantial deficit reduction while preserving access to health care for these vulnerable citizens.



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Now, Mr. Miller, as Chairman of this Committee, I am prepared to offer the Administration an opportunity to make its case, and I'm prepared to hear you out. But I don't think we need to revisit here the Administration's rationale for requesting further Medicare cuts -- that, by your assessment, the Reconciliation bill fell short of the savings targets agreed to in the summit. The fact of the matter is that the President ratified the summit agreement when he put his signature on the Reconciliation bill. Members of this Committee worked with the Administration in a remarkable spirit of cooperation to address the deficit problem, but with the understanding that our deal was a deal. Should the Administration reopen the summit agreement by continuing to insist on another round of Medicare cuts even though economic conditions remain steady, I predict a rocky year. If a deteriorating economy forces Congress to take further action on the deficit, I would be reluctant to consider further reductions in Medicare. I am, however, pleased that Secretary Bowen is here today to share with us the policy rationales underlying the Administration's recommended changes in the Medicare program -- some of which result in budget savings.

A substantial portion -- 74 percent -- of the proposed savings come from further reductions in payments to hospitals. I would be interested in hearing from you, Mr. Secretary, about a problem we face every year, that Medicare spending reductions rely heavily on restraining hospital spending and far less on physician reductions, despite the fact that Medicare physician payments are growing twice as fast as hospital payments. Indeed, the physician reforms included in the Budget by and large simply extend or magnify reductions agreed upon during the budget summit last year. In general, the President has proposed making additional cuts in physician payments across-the-board, rather than using the approach this Committee has favored in the past which focuses reductions on high-cost providers. I would be interested in hearing your thoughts on this issue, Mr. Secretary.

The Budget includes $980 million in proposed cutbacks in hospital payments, and focuses these reductions on teaching hospitals. The Senate approved reductions in indirect medical education last year that, while greater than those included in the final Reconciliation conference agreement, are nowhere near the almost $1 billion savings proposed in the Budget. I'm deeply concerned about the potential impact of cutting the indirect teaching payment all the way back to 4.05 percent.

In the direct medical education area, Mr. Secretary, I want to commend you for protecting Medicare support for nursing education, which is an area in which the Administration has proposed cuts in previous years. I know how strongly members of this Committee feel about cutting back nursing education at a time when this country faces a dire shortage of nurses.

I am gratified to see that the Budget appears to fulfill OMB's agreement with the Committee to provide adequate funding for Peer Review Organizations, and hope that we can receive more detail on the Secretary's plans for this program.

I would also like to note that, while I'm pleased to see that the Administration has dropped its ill-advised proposal for a "cap" on Medicaid spending, the Budget does assume that the Secretary will issue certain regulations which would reduce Medicaid spending by $413 million in Fiscal Year 1989.

Let me say a word about one of these regulations. Mr. Secretary, I'm sure you're aware that several members of this Committee are from States who would be severely affected should the Department move to limit the use of donations as the State share of Medicaid. I know this is of deep concern to Senator Rockefeller and perhaps Senator Pryor and, in fact, this is an issue for my own State of Texas. Mr. Secretary, I hope you'll keep us apprised of developments in this area.

In putting together the budget summit agreement last year, we substantially reduced spending overall, but we did manage to identify a few areas where increased resources were badly needed. One of these areas is the title XX social services program which is an entitlement program controlled by an overall cap. Because this cap has been constant since 1984, the program's ability to meet the needs it serves has declined in real terms. Consequently, we managed last year to provide a small but important increment of $50 million on a one-time basis. I am concerned to note that the President's budget simply ignores this change in the law. This is an entitlement program and the basic statute now entitles the States to draw down the additional $50 million. The President's budget does not (and should not) propose to repeal this entitlement. I do not understand how, then, the budget can fail to accommodate this amount which Congress and the President have already agreed to in last year's reconciliation bill.

I am dismayed that the Administration once again proposes to mandatorily extend Medicare to all state and local employees.

In 1985, Congress mandatorily extended Medicare to state and local employees hired after March 30, 1985. By only covering newly hired employees, we wisely allowed state and local governments a phase-in so those governments could absorb the cost of mandatory Medicare coverage gradually without the curtailment of vital public services. Ever since 1985, the Administration has proposed to eliminate that phase-in at a great cost to state and local governments and individual employees. Congress has rejected that idea every year, and I believe the idea will be rejected this time as well.

In the welfare area, I note that the President's budget includes modest funding for a welfare reform program. The amount is based on a specific proposal, and the bill that ultimately becomes law will likely differ substantially from that proposal. But I take the President's inclusion of this item as an encouraging sign that the Administration intends to cooperate in advancing this important issue towards enactment.

The House has passed a bill. This Committee and Senator Moynihan's Subcommittee have each spent much time and effort exploring the issue in hearings. It would be a shame not to conclude the matter this year.

I am very hopeful that we will be able to put together a bill which the House, the Senate, and the President can all endorse to help families with children improve their lives and free themselves from dependence on welfare.

STATEMENT BY

SENATOR JOHN H. CHAFEE

ON

ADMINSTRATION FISCAL YEAR 1989 BUDGET PROPOSALS

SENATE COMMITTEE ON FINANCE

MARCH 3, 1988

Mr. Chairman, I appreciate this opportunity to listen to the Administration's Medicare and Medicaid proposals for Fiscal Year 1989. I have briefly reviewed the summaries they have provided and am interested to hear Secretary Bowen's thoughts.

I will simply state that I am concerned about the reductions proposed by the Administration.

Over the past five years the Medicare program has borne the brunt of Congress's efforts to reduce the federal deficit. In just six years time, this program has contributed over 30 billion dollars toward savings to reduce the deficit. Each year we have restricted the funds for reimbursement of hospitals, physicians and other health care providers. However, at the same time concern about the quality of care provided by these individuals and institutions has increased.

We can only do so much so fast without sacrificing the quality of care provided and Medicare beneficiaries' access to that care.

**OPENING REMARKS FOR FINANCE BUDGET HEARING**
**SENATOR JOHN D. ROCKEFELLER IV**
March 3, 1988

Mr. Chairman, like you, I am more than a little surprised to find ourselves considering a proposal to make major cuts in Medicare. It was not easy to achieve the savings that are now in place. This entire committee, however, bit the bullet during the final months last year and came to an agreement with the House and the Administration that reduces Medicare spending by $2 billion this fiscal year and another $3.6 billion in 1989.

I remember this as being a two year agreement. Now, we find ourselves with a budget proposal from the President that questions the amount of savings the reconciliation bill will produce and calls for some substantial cuts, on top of those we made for these two years, in payments to hospitals and physicians and in other aspects of Medicare and Medicaid.

I realize my perspective is one that comes from representing a state where the problems in health care are especially serious -- for the elderly, for the disabled, and for the poor especially. There are thirty-five rural and small hospitals in my state that are experiencing some very scarey financial losses. In a state as small as West Virginia, the threat of five or more hospitals closing their doors permanently this year is agonizing. Our communities are having a difficult time keeping or attracting doctors, and it doesn't help when those doctors know most of

their patient load are on Medicare, Medicaid, or without any health insurance whatsoever.

I believe the process of deficit reduction must be one of setting priorities, spreading the burden and the pain of budget cuts, and even raising new revenue in a fair manner. But, in the case of Medicare -- and I should add, in the case of other essential programs within HHS that are targetted for big cuts or even elimination -- I am inclined to say for now that "enough is enough." The days of so-called Medicare profits for hospitals seem to be over, and even the Inspector General's report recently acknowledged that rural hospitals are losing money in many cases when caring for Medicare beneficiaries. Unless circumstances drastically change, I am unwilling to ask health care providers and patients to take any more of the brunt.

I am willing, like always, to listen to what the Administration has to say in defense of its budget proposal. And I should add that I am grateful for some of the more positive aspects of this proposal -- some long-standing favorites of the Administration have disappeared, like the cap on Medicaid or the idea of cancelling the up-date for hospitals. There is always room for more productivity and efficiency. But I'm disturbed by and skeptical of this budget proposal. I worry that numbers may be driving these specific policy recommendations, and not concern about the quality of health care, and access to health care, for the elderly and poor.

SENATOR DAVE DURENBERGER
STATEMENT ON THE PRESIDENT'S BUDGET
FOR FY89
MARCH 3, 1988

Mr. Chairman, this morning's hearing should provide us with a good overview and analysis of the President's final budget. Unlike the eight previous budgets submitted by the President, to Congress, this one appears to have a better chance of surviving mostly intact. And that's because the October 19, stock market plunge provided a window of opportunity for the Congressional leadership to work with the President to develop a two-year budget agreement.

There are several positive features of the President's budget that deserve attention. The President's proposal to increase funding to reduce infant mortality and add to substance abuse programs, is a welcome recognition of the importance of these programs to our society as a whole. And there is no doubt that the 40 percent increase in funding for AIDS research and education is urgently needed. While I am pleased that serious attention is being given to these important problems, I am disappointed that the President has not asked for even more money to aggressively attack these serious national health problems and for other needs, including education, biomedical research and many other critical social problems..

In addition, I must strenuously object to the proposal to make further cuts in the Medicare program. Every public opinion survey I've seen makes clear that Americans care deeply about having access to high quality health care and are even willing to pay higher taxes to fund Medicare. I believe we have cut enough out of Medicare and I intend to oppose the Administration's efforts to make further cuts of $1.2 billion in this program.

The Administration is proposing that we make across-the-board reductions in provider and supplier payments. Mr. Chairman, these cuts come on top of cuts already scheduled which adversely affect all hospitals, especially those in rural areas.

If there are to be reductions, I recommend, instead of making across-the-board cuts, that the Health and Human Services Secretary come forward with a plan that will exempt those hospitals and other providers and suppliers that receive lower payments already under Medicare for a variety of historic reasons, and make larger reductions for hospitals who have inexplicably received higher payments, simply because they had high costs and charges in the past.

Although it's much easier to cut costs uniformly, such an approach guarantees that some hospitals, especially the small rural hospitals, will suffer greater financial stress than the hospitals that operate in metropolitan areas with high Medicare charges. Also, other providers and suppliers who have had relatively low fees and charges are unfairly treated when cuts come down from Washington in an across-the-board way.

We must redress the imbalance in geographic distribution of Medicare payments across the country. Why should seniors in Grand Marais, Minnesota, be denied access to a health service or plan of their choice simply because Medicare pays inordinately high amounts in Miami, Florida, for the same type of patients receiving the same type of service and there is no money left?

The payroll tax and Part B premium is no lower for my constituents in Minnesota even though they certainly get a lot less in Medicare payments on their behalf. The disparities are really dramatic in the Medicare HMO Risk contracts in rural areas, as we have seen in Minnesota and other places in the country as HMOs give up trying to provide coverage to Seniors and the disabled because the federal payments (AAPCC) are totally inadequate. Some counties get only one third of what a beneficiary would receive in Dade County Florida.

Mr. Chairman, the Administration has also proposed several changes on the tax side of the ledger. I have long supported many of these proposals, especially the effort to make the R&D credit permanent, and the proposal to resolve the issue of how companies are to allocate their research and development expenses. I am convinced the Administration is supporting these proposals because of the strong leadership of my colleagues Jack Danforth and Malcolm Wallop.

However, I must register my strong objection to the Administration's often repeated proposal to increase taxes on state and local employees and state and local governments. For the third year running, the Administration has proposed that all state and local government employees be required to pay the Medicare payroll tax. This represents a 10 billion dollar tax increase that will be have to be borne by millions of state and local government workers, and thousands of state governments.

Mr. Chairman, for years, state and local government employees were specifically excluded from participation in the Medicare system. These public employees and their government employers have taken great pains to create a sound and secure retirement health benefit system. I see no reason to now disrupt these systems and place them at financial risk solely because the federal government has now decided it needs an extra 10 billion dollars.

Moreover, Mr. Chairman, where are these local governments going to find the money to pay their share of Medicare? Will Killeen, Texas, or Alexandria, Minnesota be able to use some of their federal revenue sharing funds to help offset the additional 5 billion dollars they will have to pay? You and I both know that's not an option, since Congress took away this vital program two years ago.

Mr. Chairman, I look forward to working with you to ensure that state and local employees and their hard-pressed local governments are not required to ante up another 10 billion dollars to the federal government.

Finally, I would note that the Administration has failed to mention whether it supports the repeal of a provision that was adopted in last year's reconciliation bill. I am referring to the provision requiring farmers to pay the 15 cents per gallon diesel excise tax and then file for a refund with the IRS.

Mr. Chairman, this provision is scheduled to go into effect in less than a month. It is an absurd provision that never should have been adopted and should immediately be repealed. I hope that the Administration's silence on this issue can be construed to indicate its support for the provision's repeal.

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STATEMENT BY

OTIS R. BOWEN, M.D.

SECRETARY OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee:

Good Morning, Chairman Bentsen, Senator Packwood and Members of the Committee.

I am pleased to have this opportunity to come before the Committee again and discuss with you the fiscal year 1989 budget for the Department of Health and Human Services. With me, to my right is Chief of Staff Tom Burke, and to my far left is Assistant Secretary for Management and Budget Tony McCann, and to my immediate left is the Deputy Assistant Secretary for Budget, Dennis Williams.

Before starting, let me take a moment to express to the Committee, and especially to Chairman Bentsen, Senator Packwood, Senator Mitchell, and Senator Chafee, our deep thanks for the leadership role you took in crafting a bipartisan budget agreement which was acceptable to the Administration. I am convinced that our success in seeing a reconciliation bill enacted was due in no small part to your round-the-clock efforts.

The fiscal year 1989 budget for the Department of Health and Human Services reflects the principles established between the Congress and the Administration in the Bipartisan Budget Agreement reached late last year. We seek to achieve meaningful deficit reduction while maintaining our national commitments to health, income support and social services. We also look forward to working with the Congress to shape a budget-neutral, financially sound catastrophic health care proposal, as well as continuing our dialogue on long term care legislation.

The HHS budget calls for spending a total of $396.8 billion in 1989, an increase of 5.8 percent over 1988. It is a budget constructed from clearly established priorities for health and human services. Among these priorities are:

- increased spending for AIDS
- continued protection for Social Security and Supplemental Security Income beneficiaries
- improved quality of care

For Social Security, the 1989 budget shows total OASDI expenditures of $235 billion, an increase of $14 billion over the 1988 figure. These increased Social Security expenditures are due to cost of living adjustments (COLAs), the normal expected growth in the numbers of beneficiaries and initial benefit levels. The President's budget includes a full COLA for January 1989 estimated at 4.2 percent.

OASDI revenues for 1989 keep pace with the increased expenditures and amount to $280 billion, about $22 billion more than 1988.

In the Supplemental Security Income (SSI) program, the 1989 outlay estimate is $12.5 billion, a decrease of $162 million over 1988. The decrease occurs because there are 13 monthly payments in 1988 and only 12 in 1989. But the rate of Federal expenditures is increasing, due largely to cost of living increases and more beneficiaries.

Medicare spending is of great concern to us all, and we are estimating a 7.8% increase in total Medicare outlays between 1988 and 1989. This would bring 1989 expenditures to $94.5 billion.

Our budget includes a variety of proposals intended to control the rate of health care spending, while assuring quality health care and access for program beneficiaries.

To curb the high rate of increase in out of hospital costs, we are proposing several legislative changes in 1989 in Medicare Part B to correct certain physician overpayments and reduce gross spending by over $300 million:

- Medicare payment to physicians for the 12 "overpriced" procedures reduced by OBRA 1987 would be further reduced by 5 percent.

- Payment rates for all radiology and anesthesiology services would be reduced by 10 percent and the fee schedules for these services required by OBRA 1987 would be delayed until January 1, 1990.

- Payment for medical direction of anesthesia services performed by an operating surgeon would be eliminated after December 31, 1988.

We are also proposing several non-physician reimbursement reforms.

- The fee schedule for the category of durable medical equipment that includes wheelchairs and hospital beds would be based on average allowed charges rather than submitted charges.

- We would reduce oxygen payments by 5%.

- Another proposal would limit payment for beneficiaries who elect to receive home dialysis services directly from a supplier rather than a facility to a national average composite rate.

- Finally, we have a proposal that would establish what is essentially a fee schedule for enteral products and supplies based on wholesale and retail price information.

We believe that it is important for consumers to have a stake in cost sharing for routine services. Therefore, we propose to make the 25 percent beneficiary share of the Part B program permanent, beginning in 1990. Beneficiaries would be protected by a hold harmless provision that limits premium increases to preclude an absolute reduction of their Social Security check.

While PPS update factors have reduced average hospital operating margins, there remain subsidies in the hospital system which are clearly excessive. Consequently, the 1989 budget contains almost $1 billion in proposals to reduce Part A Medicare outlays.

- One would reduce the factor used in making indirect medical education adjustments to 4.05 percent.

- Another proposal would insure that graduate medical education payments are based only on costs related to salaries and salary-related fringe benefits.

- A third proposal would make Medicare secondary payer requirements and enforcement mechanisms more uniform and simplify administration.

To ensure that individuals who now qualify for Medicare on the basis of short periods of work contribute their fair share to the Hospital Insurance Trust Fund, we would include under Medicare state and local employees hired before March 31, 1986.

To achieve health care quality, our major initiative is to increase outlays for Peer Review Organizations to $322 million for 1989, up from $191 million in 1988.

The Department continues to be strongly committed to the concept of consumer choice in a health care system to both ensure access for beneficiaries and give them a voice in influencing health care costs.

The Medicaid budget would spend nearly $33 billion in 1989, $2 billion over 1988.

There are no legislative proposals for Medicaid in this year's budget. However, the budget reflects a number of Medicaid regulatory initiatives designed to encourage more cost-effective health care and clarify reimbursement policies. These regulations would save about $413 million in 1989.

FAMILY SUPPORT PAYMENTS TO STATES

The Family Support Payments to States request includes $10.8 billion in outlays for the Aid to Families with Dependent Children program and the Child Support Enforcement program. We are especially pleased to report that overall collections for child support payments will total $5 billion in 1989. This is up by 12.4 percent over the previous year.

Also, to help reduce unpaid child support obligations in interstate cases, we plan a telecommunications network to link all States, increasing the effectiveness of interstate enforcement.

Welfare Reform

We are asking for your support of S. 1655, the AFDC Employment and Training Reorganization Act of 1987. This legislation contains several features we consider essential to welfare reform.

It would provide broad demonstration authority to enable States and communities to test innovative alternatives to the current welfare system and consolidate programs and cut out conflicting administrative requirements.

It would also ensure that many people on AFDC receive work and training services, keeping young parents in school or participating in education or job training.

It would also allow States flexibility in determining the scope of AFDC benefits. So States with limited resources could focus their resources on families they feel are most in need.

Finally, it promotes fiscal restraint in this time of budget deficits.

## OFFICE OF HUMAN DEVELOPMENT SERVICES

We are requesting $4 billion in 1989 for programs under the Finance Committee's jurisdiction administered by the Office of Human Development Services.

Included in the request is the full authorization of $2.7 billion for the Social Services Block Grant to States which supports child day care, child and adult protection, home management and maintenance, employment and legal assistance and transportation.

### FOSTER CARE AND ADOPTION ASSISTANCE

For Foster Care and Adoption Assistance the budget totals $1.1 billion, an increase of $264 million over 1988. expenditures.

These resources will help to keep families together, support children who cannot live with their families and provide adoptive homes when reunification isn't possible. Included are funds to pay State claims for prior year expenditures.

MATERNAL AND CHILD HEALTH

The Department is working to reduce infant mortality. To help insure the health of our children, we are supporting expanded efforts by community and migrant health centers to develop targeted, innovative approaches to reducing low birthweight and infant mortality. The Maternal and Child Health block grant is a major component of our effort. Our 1989 request is for $561 million, an increase of 6.5 percent.

In conclusion, Mr. Chairman, I believe we have a major opportunity this year to take further steps to control the growth of health care spending and reduce the Federal deficit. We also have a chance to make historically significant changes in developing the final form of catastrophic health insurance and welfare reform. I very much look forward to working with this committee and the Congress to complete these important tasks. I would be happy to answer any of your questions.

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

STATEMENT
of
JAMES C. MILLER III
DIRECTOR
OFFICE OF MANAGEMENT AND BUDGET
before the
FINANCE COMMITTEE
of the
UNITED STATES SENATE
March 3, 1988

Mr. Chairman and Members of the Committee: I am pleased to be here to discuss Medicare and the other entitlement programs under your jurisdiction. I know you have a particular interest in the $1.2 billion reduction in Medicare included in the President's FY 1989 budget, and so I'll deal with that first.

## Need for Additional Medicare Savings

The Bipartisan Budget Agreement negotiated last November called for Medicare savings of $2.0 billion in FY 1988 and $3.5 billion in FY 1989. These savings were not in fact "cuts", since even with them the level of Medicare spending continues to rise. Instead, with the savings imposed by the Agreement there is a slight reduction in the rate of growth in Medicare expenditures.

Our estimates of the effects of the changes incorporated in last year's reconciliation bill relied on the experience and expertise of the Medicare Actuary at the Department of Health and Human Services (HHS). By his scoring, reconciliation reduced spending over two years by $1.2 billion less than called for in the Bipartisan Budget Agreement. So, to meet the terms of the Agreement, the President's budget proposes $1.2 billion in additional Medicare savings.

A little background probably would be helpful. During the first day of the Bipartisan Budget Negotiations last November it was agreed that we would use, as a spending and revenue baseline, the Office of Management and Budget's (OMB's) Gramm-Rudman-Hollings (G-R-H) report published on October 20, 1987. Recognizing that estimating entitlement savings -- particularly in Medicare -- is always tricky, the Bipartisan Budget Negotiators, in their release describing the Agreement, indicated that "CBO and OMB shall work together to resolve scoring methodology problems on mandatory accounts."

During the intitial negotiations with this Committee,

Congressional and Administration experts worked out differences in scoring. As you know, Mr. Chairman, the Administration supported your provisions in the Senate reconciliation bill. However, in the Conference negotiations the Administration's experts were shut out of the process. Despite the admonition in the Bipartisan Budget Agreement release, there was no opportunity for discussions over scoring methodology. Instead, in the end, the Conference adopted Congressional Budget Office (CBO) scoring -- which, as I have indicated, purported to provide estimated savings of $1.2 billion more than that established by the Medicare Actuary.

This outcome we found particularly disturbing. First, it violated the admonition in the Bipartisan Budget Agreement release to which I have just alluded. Second, under G-R-H procedure, it is the OMB scoring that counts, not CBO's, in determining whether we ultimately meet our deficit reduction targets. (Otherwise, the G-R-H procedure is unconstitutional.) Third, the Chairman of the Bipartisan Budget Negotiators, House Majority Leader Tom Foley, had repeatedly said publicly that the Agreement's savings, in the end, would be scored by OMB. And fourth, when OMB's estimates of savings were higher than CBO's in other areas, such as agriculture, Congress chose to use the higher scoring.

The largest difference in OMB vs. CBO scoring can be traced to the choice of a baseline for measuring the savings in hospital payments under the Prospective Payment System (PPS). In the past three years, once all the factors affecting hospital costs were addressed, the PPS increase has averaged one-fourth of the hospital inflation index. This is due in part to the widespread recognition that when the PPS system was first established in 1983, it was greatly inflated; thus, calls for "rebasing" have been dealt with by allowing substantially less than the full inflation index. However, in scoring the Medicare savings, the Conference assumed full inflation in its baseline and against that inflated baseline estimated $245 million in savings in FY 1988 and $1.4 billion savings in FY 1989. On the other hand, we reviewed all the factors that under law must be considered when setting the PPS update, and established a baseline reflecting an update factor of one-half the hospital inflation index. Let me say once again: recent experience has shown the actual update factor to be only one-fourth the inflation index, so our update at one-half was quite generous. On this basis, the Medicare Actuary estimated the Medicare savings to be $180 million for FY 1988 and only $250 million for FY 1989.

Although the PPS baseline accounts for most of the

variation in OMB and CBO estimates for Medicare, other factors affecting other items, such as different assumptions about demand for services and the rate of implementation of spending reductions by the agency, can also affect the accuracy of the estimates. The Bipartisan Budget Agreement's requirement that OMB and CBO work together to resolve methodological differences recognized that consistency was important.

Unfortunately, the Conference's decision to exclude the Administration's experts and to rely on CBO's savings estimates resulted in overall spending estimates with known inconsistencies. For example,

- The Medicare Actuary estimates that the provision that extends the Part B premium at 25 percent of Part B costs will save $645 million in FY 1989, while CBO estimates savings will be only $260 million.

- For most provisions that are intended to limit spending on physicians, CBO scores greater FY 1988 savings than does the Medicare Actuary. For example, CBO estimates that the provision that limits the inflation increase for physician services saves $735 million in the two years FY 1988 and FY 1989, while the Medicare Actuary estimates total two-year savings of $530 million. In contrast, the Medicare Actuary estimates much smaller FY 1989 costs ($5 million versus CBO's $30 million) for a provision that pays physicians in rural underserved areas a bonus, because the actuary assumes far fewer physicians.

- The Medicare Actuary assumes that a series of changes to the way Medicare pays for durable medical equipment will increase costs over time, while CBO estimates net savings will result. The total difference is $100 million in FY 1988 and FY 1989 combined.

- The Medicare Actuary estimates lower costs for an expanded mental health benefit than CBO did ($90 million over two years versus CBO's estimate of $140 million over two years).

Let me make the point here that even with the additional $1.2 billion savings in Medicare proposed by the Administration to meet the terms of the Bipartisan Budget Agreement, spending for this program continues to increase at a rate far exceeding that of defense, social security, and interest on the federal debt. Despite well-publicized "cuts" in Medicare spending, actual outlays increased from $39.1 billion in FY 1981 to an estimated $78.9 billion in FY 1988 -- more than <u>double</u>. And despite a series of reforms

and incremental changes, spending on physician services also has more than doubled -- from $9.5 billion in FY 1981 to an estimated $24.7 billion in FY 1988.

Given the situation, I urge this Committee to approve the Administration's proposal, the matter to which I now turn.

## Administration's Medicare Savings Proposal

The President's budget proposes to reduce the increase in FY 1989 Medicare spending by $1.2 billion, in order to implement fully the two-year savings target agreed to in the Bipartisan Budget Agreement. In Part A (Hospital Insurance) savings would be achieved by:

- Reducing the indirect medical education add-on to PPS from 7.70 percent to 4.05 percent. Teaching hospitals receive an add-on payment to account for the historically higher costs associated with teaching care. This adjustment was doubled arbitrarily when the PPS system was instituted. In 1986, teaching hospitals received PPS payments that were an estimated 13 percent in excess of operating costs -- making teaching hospitals the most advantaged class of hospitals under PPS. The President's budget proposes to reduce the teaching add-on to a more analytically appropriate level, and to make the ratio of payments to costs for teaching hospitals more consistent with other classes of hospitals.

- Limiting the per-resident payment for graduate medical education to a resident's actual stipend, fringes, and overhead directly related to classroom activities. These payments were intended to be transitional when initiated, but effectively have become a permanent subsidy to those receiving them.

A series of incremental reforms in Part B of Medicare would also help limit the future increase in the Part B premium which is paid by the nation's aged and disabled. These reforms include:

- Setting the CY 1989 prevailing charges for 12 specified groups of currently-overpriced physician procedures at CY 1988 levels, reduced by 5 percent, subject to a national floor.

- Delaying the use of a fee schedule for radiologic services until January 1, 1990; instead, reducing payments to radiologists by 10 percent in CY 1989.

- Delaying the use of a relative value guide for anesthesiology services until January 1, 1990; instead, reducing payments to anesthesiologists by 10 percent in CY 1989, and basing future payment amounts on the CY 1989 level.

- Eliminating duplicative payments for physicians performing surgery while supervising certified registered nurse anesthesiologists providing anesthesia services.

- Establishing a fee schedule for enteral products, supplies, and equipment based on the lesser of existing lowest charge level limits and national limits derived from wholesale and retail price information; Medicare would pay the lesser of actual charges and the fee schedule amounts.

- For durable medical equipment and prosthetic devices subject to the OBRA 1987 rental cap which is the lesser of actual charges and fee schedule amounts: (a) allowing the purchase and lease-purchase of such items, as permitted prior to OBRA 1987; (b) basing fee schedules for these items on average reasonable charges or discounted submitted charges rather than submitted charges; and (c) limiting rental payments to 15 months in the case of lease-purchase and 13 months in all other cases.

- Limiting payments for oxygen equipment and supplies to 90 percent of an inflation-adjusted base rate, based on the CY 1986 average monthly reasonable charges calculated by each carrier.

- Standardizing Medicare payments for End-Stage Renal Disease (ESRD) under Method II, which permits beneficiaries to acquire home dialysis equipment and supplies from suppliers. Medicare payments for Method II, now based upon reasonable charges, would be limited to the national average ESRD composite rate. To ensure fair treatment, requiring that beneficiaries obtain an agreement with one supplier to furnish all dialysis supplies and equipment.

- Making the penalty provision for employer non-compliance with working aged and End Stage

Renal Disease (ESRD) secondary payer provisions conform to that of the working disabled; that is, requiring employers violating those secondary payer provisions to pay an excise tax equal to 25 percent of the group's health plan's expenses.

Even with the changes the Administration proposes, Medicare spending will increase by 6.5 percent from FY 1988 to FY 1989 -- slightly more growth than could be explained by beneficiary increases and inflation. Over the long run, Medicare growth is still projected to be remarkably high. Medicare spending will increase by an estimated 62 percent by FY 1993 -- from the current (FY 1988) spending level of $79 billion to $128 billion. Between 1980 and 1993 -- 13 years -- the program will quadruple under current projections. Medicare would thus become the largest single Federal spending program by 2010 -- exceeding spending for Social Security and Defense combined.

## Adminstration's Other Proposals

### Medicaid

The Adminstration's request for the Medicaid program is $32.7 billion for FY 1989 and $35.8 billion for FY 1990. Spending under current law for the Medicaid program is projected to increase by 9.5 percent in FY 1989.

Consistent with the Bipartisan Budget Agreement, the Administration will not propose legislation for the Medicaid program this year. As always, the Budget contains a set of regulatory and administrative initiatives. Such initiatives are part of the ongoing process of fine tuning the program, responding to change, and incorporating new ideas to improve the system. The budget effect of these initiatives is a net reduction of $413 million in FY 1989. Not all of these initiatives are intended as cost containment measures, but are, instead, efforts to clarify current policies. Those that are intended for cost containment are measures which will provide guidance and encouragement to the States to adopt practices which will provide for greater equity in the system and to promote more cost effective and higher quality medical care.

### Catastrophic Health Insurance (CHI)

Catastrophic health insurance legislation proposed by

the President is now awaiting final conference action. Throughout the catastrophic health insurance debate, the Administration has remained firmly committed to the goal of providing affordable, acute-care catastrophic illness protection.

The President's original proposal called for a responsible, deficit-neutral program that limited the expenses a beneficiary would have to pay out-of-pocket for Medicare-covered services in any given year. Beneficiaries would have paid for this increase in protection with a modest increase in premium.

The House of Representatives, in passing an alternative catastrophic health insurance bill (H.R. 2470) in July of 1987, converted the President's sound, reasonable proposal into a massive program that imposed a prohibitive tax increase on the elderly and threatened bankruptcy for the Medicare trust funds. The House went well beyond providing catastrophic protection, adding a prohibitively expensive outpatient drug benefit and numerous other Medicare and Medicaid expansions unrelated to acute-care catastrophic protection. The House approved this excessively expensive bill, rejecting a responsible alternative introduced by Representative Michel.

Working together, the Administration and Members of this Committee produced a sound catastrophic health insurance bill -- one consistent with the mutually accepted principles of sound financing, affordability, and deficit neutrality. The Senate-passed bill guaranteed that a constant percentage of beneficiaries would receive catastrophic protection each year and assured an outpatient prescription drug benefit that remained soundly financed by an affordable premium.

As you begin a difficult and potentially contentious conference with the House, I want to assure you that the Administration remains committed to the enactment of legislation providing affordable, acute-care catastrophic illness protection and outpatient prescription drug coverage for our nation's elderly and disabled. However, such legislation must be deficit neutral, with benefits paid from newly created trust funds that are soundly and fully financed from beneficiary premiums.

Maternal and Child Health Block Grant

The Administration's FY 1989 budget request includes $561 million for the Maternal and Child Health Block Grant

-- an increase of $34 million or 6.5 percent over the FY 1988 level. This request is at the full authorization level. It will provide States with a stable source of financial support, targetting a broad range of services for maintaining and improving the health of mothers and children.

Hospital Insurance -- State and Local Coverage

As you know, State and local government employees hired after March 31, 1986 pay for and receive Hospital Insurance coverage under Medicare. The President's budget extends this valuable coverage to all State and local government employees regardless of when first hired.

This is an important provision. Among those employees hired before April 1, 1986, nearly 25 percent are not assured of hospital, physician, and related Medicare protection because their jobs are not covered by Medicare.

At the same time, this provision eliminates tremendous Medicare windfalls that nearly 75 percent of uncovered State and local employees will receive due to loopholes in the system. We must require these individuals to pay their fair share for coverage. Also, this will help lessen the drain on the financially troubled Hospital Insurance Trust Fund.

For your information, this provision generates revenues in excess of costs for the Hospital Insurance Trust Fund in the short run. In the long run, however, Medicare costs will exceed revenues, because Hospital Insurance coverage includes later eligibility for Supplemental Medical Insurance, which currently receives a 75 percent general fund subsidy.

AFDC and Child Support Enforcement

Mr. Chairman, your Committee has before it S.1655, the AFDC Employment and Training Reorganization Act of 1987. This proposed Act builds upon new research and lessons learned from the States and would put in place a process for learning more about how to prevent and reduce welfare dependency. The President has endorsed this forward-looking and responsible legislation.

Under S.1655, States would be expected to involve meaningful and growing numbers of AFDC recipients -- particularly those likely to become long-term dependents -- in activities to increase their self-sufficiency. In

exchange, States would receive almost triple the Federal resources dedicated to employment and training programs for AFDC recipients. And these funds would still stay within the domestic discretionary spending cap agreed to in the Bipartisan Budget Agreement.

S.1655 also would strengthen our Federal-State Child Support Enforcement program. Mandatory use of State-established guidelines in setting award amounts, automatic wage withholding of court-ordered support payments, and improved procedures for paternity establishment and inter-State enforcement of child support -- all of these provisions under S.1655 would help ensure children receive adequate and timely support from their absent parents.

In addition to specific changes in AFDC employment and Child Support Enforcement, S.1655 includes the broad demonstration authority sought by the President to allow for careful testing of innovative alternatives to current arrangements in the large array of programs that constitute our public assistance "system". The lessons learned from the demonstrations undertaken under S.1655 would inform policy-makers for years to come.

We urge your support of this bill.

Social Services Block Grant

The President's FY 1989 budget requests provides funding for the Social Services Block Grant (SSBG) at the full authorization level of $2.7 billion. Child day care, child and adult protective services, home management and maintenance services, employment and legal services, and transportation will continue to be supported by the States through SSBG grants.

Foster Care and Adoption Assistance

For FY 1989 the President requests $1.1 billion for Foster Care and Adoption Assistance. These resources will fund programs to keep families together, support children who cannot continue to live with their families, provide adoptive homes when reunification of children and families is not possible, and support research and demonstrations designed to strengthen families and reduce barriers to the adoption of children with special needs.

Consistent with the Bipartisan Budget Agreement, the Administration's request represents HHS' most recent current services estimates, and includes $109 million to pay approved State claims for foster care expenditures before 1987, commonly known as prior years' claims. We remain concerned that State administrative costs associated with these programs have increased 500 percent over the last four years. Worse yet, administrative costs in 16 States have increased over 1,000 percent.

The President's budget requests $832 million for the Foster Care program to provide maintenance payments for children who must live outside their homes. This is an increase of $174 million over the FY 1988 level. The FY 1989 request reflects increased State claims, as noted particularly for administrative costs, and a slight increase in the average monthly number of children in foster care to 115,000.

The request of $134 million for Adoption Assistance represents an increase of $26 million over the FY 1988 appropriated level. This request reflects increased State expenditures and continued growth in the number of children assisted to nearly 44,000.

Social Security Administration

Consistent with the Bipartisan Budget Agreement, the Administration proposes no legislative changes in social security financing or benefits. Also, there are no proposed changes for the Supplemental Security Income program or for the Special Benefits for Disabled Coal Miners.

Railroad Retirement Board

Let me turn now to a specific proposal included in the President's budget -- privatizing the rail industry's pension system.

As you may know, the rail pension fund has a long history of financial crises. Congress was forced to enact major rail pension financing legislation in 1974, 1981, and 1983 to prevent insolvency. These refinancing laws were supposed to put rail pensions on a sound financial track, but in each instance revenue projections proved to be too optimistic. Railroad Retirement Board (RRB) actuaries are again projecting that the rail pension fund will go broke.

The Administration believes the long-term solution for rail pension solvency lies in the private sector. Restoring rail pensions -- that is, the amounts above Social Security equivalent levels -- to the private sector would free rail labor and management to bargain collectively their pension system without inappropriate Federal intrusion. Also, privatization would ensure sound financing of rail workers' pensions by extending Employee Retirement Income Security Act (ERISA) financing rules to new rail workers and giving full Social Security coverage to all rail workers. We plan to transmit privatization legislation to Congress late this year.

We also believe it is advisable to reverse section 9034 of the 1987 Omnibus Budget Reconciliation Act, which gives $390 million to the rail sector's pension fund. Such subsidies dilute the incentive for rail labor and management to negotiate in good faith for a solution that does not include large taxpayer support. Removing the subsidy would send the message that the rail sector must be held to its longstanding commitment to pay for its own pensions.

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Mr. Chairman and Members of the Committee: that completes my prepared statement. Now, I shall be happy to address any questions you might have.

STATEMENT OF ROBERT J. SCOTT

ON BEHALF OF

ORGANIZATION FOR THE PRESERVATION OF THE PUBLIC EMPLOYEES' RETIREMENT INDUSTRY AND OPPOSITION TO SOCIAL SECURITY EXPANSION TO SUCH INDUSTRY

(OPPOSE)

Members of the House Committee on Ways and Means, I am Robert J. Scott, secretary-treasurer of OPPOSE. OPPOSE is a Colorado corporation formed by teachers, firefighters, police, and other state and local government employees who have elected not to join the Social Security system. The purpose of our organization is to assure the continued financial integrity of our members' retirement and health insurance plans by resisting congressional efforts to mandate Social Security or Medicare coverage of public employees. Our members are found in Alaska, California, Colorado, Illinois, Kentucky, Louisiana, Massachusetts, Nevada, and Ohio. With respect to the issue of mandatory Medicare coverage, the interests of OPPOSE are identical to those of the four to five million public employees throughout the nation who remain outside the Social Security system.

Through this testimony, we wish to express our strong opposition to the proposal in the Administration's budget for fiscal year 1989 to impose Medicare Part A coverage upon all state and local government employees effective December 1, 1988.

By way of background, I would remind you that employees of state and local government were not permitted to join the Social Security system when it was established in 1935. While they have been permitted to join since the 1950s, those who have chosen to remain outside the system have their own retirement plans and, in many instances, health insurance plans.

Under current law, all employees of state and local government hired on or after April 1, 1986, are required to participate in the Medicare system. This is the result of a compromise adopted in the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), which phased in Medicare coverage gradually, by covering newly hired workers and leaving older workers grandfathered outside the system. Through

adoption of this phase-in provision, which will result in Medicare coverage of all public employees through normal job turnover, Congress ensured that all public employees will ultimately pay the full Medicare tax to the federal government. The individuals excluded from coverage under COBRA were those who were already working and for whom the Medicare tax would both constitute a pay cut and jeopardize their existing health benefits. While we at OPPOSE did not favor mandatory Medicare coverage, we believed that the phase-in provision adopted in COBRA was a reasonable, permanent solution that avoided imposing overwhelming burdens on state and local governments and their employees.

Proposals to reopen the issue and expand coverage to include all state and local government workers were wisely rejected by Congress in 1986 and 1987.

The new twist this year is that the Administration has specifically linked the proposal to expand mandatory coverage with an array of completely unrelated spending proposals. These include measures to allow companies to allocate a greater portion of research and experimentation expenditures to domestic income, to establish a permanent research and experimentation tax credit, and to exempt permanently from the two percent floor for miscellaneous deductions certain mutual fund shareholder expenses.

Because they bear no connection to the question of mandatory Medicare coverage, OPPOSE takes no position with respect to the Administration's various spending proposals in and of themselves. However, mandatory coverage is an entirely inappropriate means of financing such measures. Moreover, we at OPPOSE believe that the phase-in compromise reached in COBRA should be respected and that our employees and retirees should not be visited by the same threat year in and year out. Therefore, and for the reasons set forth below, OPPOSE asks you once again to reject the proposal to extend mandatory Medicare coverage to all state and local government employees.

1. <u>The linkage of mandatory Medicare coverage of state and local government employees with the various spending proposals incorrectly suggests that the revenues mandatory coverage would raise would be available to be spent for purposes other than payment of Medicare benefits</u>. This suggestion reflects a complete misunderstanding of the mechanism for financing the Medicare system. Like the Old Age and Survivors and Disability programs, the Medicare Part A program is funded entirely through payroll taxes, which are credited to a separate trust fund. Indeed, the Social Security Act specifically provides for the transfer to the Health Insurance ("HI") trust fund of an amount equal to the amount

raised through imposition of the HI tax. Thus any revenues that would be raised by extending the Medicare tax to a new class of individuals would automatically be credited to the Medicare trust fund. They would not become part of the general revenues and are not available, even in the short run, to fund new measures such as the establishment of a permanent research and expenditures tax credit. Any contrary assertion is simply an attempt at accounting chicanery.

By suggesting that mandatory Medicare coverage presents an available revenue source, the Administration's proposal also ignores the fact that the newly taxed individuals would also become newly entitled to benefits. Indeed, their benefits might well be relatively more expensive than the benefits of the average covered individual. Like the federal employees who were brought into the system in 1983, newly covered state and local government employees would become entitled to the full package of Medicare benefits despite having spent a portion of their careers outside the system and having paid a relatively small amount of the HI tax as a result. Particularly given the projected decline in the HI trust fund's balance in the next decade, any revenues raised by an expansion of mandatory Medicare coverage would be needed to offset the cost of additional benefits.

Recent reports have indicated that the magnitude of the deficit problem the country faces in the next decade is masked, in part, because the Social Security trust funds, which are counted for purposes of deficit calculation, will begin to build large surpluses that must be expended on benefits in the next century. Congress should not add to this problem by enacting spending proposals and claiming to fund them by revenues which are credited to the HI trust fund and necessary to pay future benefits.

2. The linkage of mandatory coverage with the Administration's various other spending proposals is also inappropriate because the revenues raised by the mandatory coverage proposal would shortly decline to zero, while the various spending proposals would require permanent sources of financing. Through the operation of COBRA's provision imposing coverage on newly hired employees, the turnover of the workforce has resulted in a larger percentage of the public employee workforce being covered each year. Correspondingly, fewer employees remain outside the system, representing a declining revenue base as time progresses. Thus, the revenues that the mandatory coverage proposal would raise will dry up entirely in a relatively short time and would not be available for any purpose in the long run. On the other hand, the items that the Administration proposes to finance through mandatory

coverage are permanent, and require a permanent source of financing. Enacting the spending proposals on the pretext that mandatory coverage would pay for the Administration's spending proposals would actually exacerbate the deficit problem.

3. Because the Administration's revenue estimates do not reflect a decline in the amount that this proposal would raise over time, the estimates are themselves open to challenge even concerning the amount that would be raised in the first year. The Administration estimates that the mandatory coverage proposal would raise $1.6 billion in fiscal year 1989 and $2.1 billion in each of the next two years. We estimate the overall turnover rate for state and local employee groups to be approximately 9 percent per year. (See Table A, attached, which sets forth data concerning the rate of coverage since implementation of COBRA in 1986.) Thus, using this estimate, approximately one-quarter of the state and local government employees who were outside the Medicare system before COBRA will be covered by the system by the effective date of the Administration's proposal, and that number is on the increase. The Administration's revenue estimates, which do not reflect a decline in revenues in the out years -- or, indeed, any decline in the revenue estimates since last year when the same mandatory coverage proposal was made -- are simply inaccurate with respect to the later years and suggest that the full effect of COBRA was not taken into account in the estimate for fiscal year 1989.

4. The proposal would have an extremely negative fiscal impact upon the affected state and local governments. While the impact of the proposal would fall most heavily upon governments in approximately 10 states,*/ forty-nine states include at least some subdivisions with non-covered employees that would be significantly harmed by these additional operating costs. Estimates of the annual cost to state and local government are set forth state-by-state in Table B, attached. For example, the proposal would cost governments in Ohio $164 million annually; the cost in Illinois would be $82 million.

Imposition of these additional costs would come at a difficult time. State and local governments have repeatedly been forced to shoulder additional burdens in recent years, resulting from considerable cuts in the federal appropriations for many of their programs and the loss of revenue-sharing, while the Tax Reform Act of 1986 limited their ability to raise revenues, through loss of the sales tax deduction and new

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*/ Alaska, California, Colorado, Illinois, Louisiana, Maine, Massachusetts, Nevada, Ohio, and Texas.

restrictions upon municipal bonds. A recent study by the National League of Cities concluded that almost one-third of U.S. cities and towns anticipate a decline in their general revenue funds this year. Many local governments must raise taxes to maintain existing public service spending levels formerly funded through revenue-sharing. The result is that state and local governments are in no shape to absorb additional fiscal burdens.

To cite a few examples, a number of California counties have recently been required to close public libraries and parks as a result of budget shortfalls. Last year, the President of the Board of Commissioners for Trumbull County, Ohio, testified that, as a result of the loss of revenue-sharing, 39,000 citizens in his county were without police protection. Many governments at all levels around the country would find that imposition of the new 1.45% Medicare tax would force them to make very hard choices among essential services and staff.

5. Despite the promise of the President not to raise taxes and the efforts of Congress to provide tax relief to lower- and middle- income individuals, this proposal targets 4 to 5 million lower- and middle-income Americans and their spouses for a tax increase that would more than offset the tax cut they received from the Tax Reform Act of 1986. The President has repeatedly promised not to raise taxes and frequently asserts that taxes may not be raised under the budget summit agreement reached late last year. Yet the mandatory coverage proposal is a proposal to raise taxes for 4 - 5 million Americans.

According to the Joint Committee on Taxation, the Tax Reform Act provided taxpayers with incomes in the range of $20,000 - 30,000 with a cut equivalent on the average to $220. The new Medicare tax that would be imposed upon state and local government employees equals 1.45 percent of payroll. Thus, to consider one example, in the case of the average government employee in Colorado (whose annual salary is $25,066), the new Medicare tax of $363 would result in a net tax increase of $143. For the average Illinois teacher, who makes $25,454 annually, the new tax of $369 would more than offset the meager $281 that now remains to such an individual annually after he or she pays for basic expenses. The increased tax burden for both would be even higher if the 1.45 percent tax that would be newly imposed upon their employers is passed along to employees.

6. The affected individuals are politically significant and can be expected to respond at the polls to a measure that singles them out for a major tax increase. Numbering between 4 and 5 million, these individuals are concentrated in such key

states as California, Texas, Massachusetts, Ohio, and Illinois. The number of public employees outside the Social Security system equals approximately 4.7 percent of the voters in the 1980 presidential election and about 3.96 percent of those who voted in 1984. In the close Senate races of 1986, the number of public employees outside of the system exceeded the margin of victory in nine states -- Alabama, Alaska, California, Colorado, Georgia, Louisiana, Nevada, North Dakota, and Washington. If the number of public employees is doubled to take into account their spouses, the number also exceeded the margin of victory in Missouri, North Carolina, Ohio, and Wisconsin. These voters can realistically be expected to influence the outcome of the presidential and local and statewide elections this year.

7. Mandatory coverage can not be justified on the grounds that it would benefit the affected employees. The Administration attempts to justify its proposal with the paternalistic concern that "[a] minority of State and local government employees. . . may not be assured of medicare coverage." The response to this concern is simple: if those public employees wanted Medicare coverage, they would have it. Since the passage of COBRA, local jurisdictions have had the option of joining the Medicare system without also participating in the Social Security system. If Medicare coverage were desirable, employees would certainly bring pressure to bear upon their employers to adopt it. In fact, the opposite is true; public employee groups are vehemently opposed to mandatory Medicare coverage and do not need the federal government to provide it "for their own good."

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For these reasons, we urge you once again and finally to reject the proposal to extend mandatory Medicare coverage to include all state and local government workers. Thank you once again for allowing me this opportunity to present the views of OPPOSE.

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